Medical schools and the virtuous physician: how to ensure that physicians will do the right thing.

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Abstract:

The focus of this thesis is moral education. This study is important as it aims at solving a prevailing and increasing problem that is harming the medical profession of our times, namely, the fact that physicians are losing touch with the nature of their profession as a moral venture. This is evident from the numerous surveys done which report complaints from patients regarding physicians' interpersonal and ethical skills. I argue in this thesis that modern day physicians experience moral erosion and that medicine is falling prey to deprofessionalization. This thesis focuses on the case of medicine in US-style universities in general and Lebanon in particular. Starting from the assumption of the ends of medicine as elaborated by Edmund Pellegrino, it asks what are the means that are most conducive to the attainment of these ends (or some of these ends)? The main conclusions are that curricular reforms must be made to ensure appropriate training of students of medicine and that the hidden curriculum is far too important to be ignored if changes are to take place and if moral erosion of physicians is to be avoided. In addition to curricular reforms, there is a need to work with veteran physicians who should serve as role models and mentors in an appropriate institutional culture, hence, there is a need for what I term a "post-flexnerian revolution". In addition to teaching students the basic sciences and skills necessary for the making of a successful physician, medical schools ought to concentrate on attempting to produce graduates that are virtuous physicians, who will do the right thing even when no one is looking. If adequate training in virtue and goodness takes place, doing the right thing will become a second nature and the moral ends of medicine will be met.

Key words: medicine, physician, student of medicine, role model, mentor, VE, virtuous physician, Pellegrino, Aristotle, ends of medicine, moral education, hidden curriculum, formal curriculum.

CONTENTS

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INTRODUCTION:

In the *Republic*, Glaucon resorts to a thought experiment and introduces the legend of the ring of Gyges: A shepherd becomes in possession of a ring that makes him invisible. Armed with this power, he starts acting unjustly: seduces the queen, murders the king and occupies his kingdom (1947, pp. 43-44). He was fearless of reprisals demonstrating that even the just man would behave unjustly if this can go unseen and unpunished. Plato wanted this myth to illustrate an important and eternal truth around which this thesis revolves: the good person is the person who will do the right thing regardless of punishment or rewards.

Applied to the practice of medicine, one can argue that the same pertains to the fine physician. She will be the kind of physician who will do what is right even when there is no one to judge her. Several forces make this ideal difficult to reach. Such forces are the same ones that are attacking what came to be known as medical professionalism: market forces, personal corruption, the economic situation, to mention but a few. Nonetheless, it is my contention that although this ideal is difficult to achieve, it is not an impossibility. One way to achieve this ideal is by nurturing good and virtuous physicians. This thesis offers an attempt at addressing this issue. The main question that this thesis deals with is what can medical schools do in order to graduate students of medicine who will possess a fine character? Put differently, what can medical schools do to graduate physicians who will serve the ends of medicine as a profession not a trade and who will do the right thing even when no one is looking? Although this thesis stresses the importance of virtues and their development in the neophyte physician; it is not a thesis on virtue ethics[1], rather on

[1]Hereafter VE.

the moral education of the neophyte physician. All through, I have taken the general setting of the US educational system in general and Lebanon in particular.

Chapter One presents a view of medicine as a moral endeavour based on the covenant of trust and argues that ethics and the virtues are essential for the making of a fine physician. In this chapter, I discuss some of the basic ideas of Edmund Pellegrino about the ends of medicine being internal to the profession. Starting from this assumption, it follows that medical schools need to educate students of medicine in ethics and virtues.

Chapter Two begins by briefly presenting Aristotle's VE and the role that it can and perhaps should play in the moral development of medical students during their years of training in medical schools. I thus argue that VE plays an important role in the formation of the good neophyte physician who will eventually be the kind of physician who will do the right thing even when no one is looking. I maintain that if virtue is to be taught, there need to be role models in medical schools and attention paid to an organizational structure and culture that allows for the growth of virtues.

Chapter three tackles the main theme of education: If medical students are to be trained in the virtues, which curricular reform ought to be made to train the students of medicine? Thus, this chapter begins by looking at the different types of curricula that play a role in the making of the future physician to show that the hidden curriculum is far too important to be neglected and as such that it plays a crucial role in ensuring that changes take place in the right direction and that moral erosion of future physicians will be avoided.

Chapter four deals with the issue of whether medical schools can do something, in addition to curricular reform, to ensure that students who graduate will actually do the right thing even when no one is looking; that they will worry about the internal ends of medicine. I

argue that this is done mostly by working with veteran physicians who will serve as role models and mentors in an appropriate institutional culture. Hence, this chapter offers a set of suggestions that can be taken on behalf of a medical school in the hope of being able to graduate the virtuous or, what I call the *Pellegrinian* physician and recommends what I call a *post-flexnerian revolution*.

To summarize, almost all medical schools offer their students a clinical training that prepares them to become dexterous and skilled medical practitioners. This thesis argues that medical schools need to do more than that: they should also offer the student of medicine training in character that will equip them to become good medical doctors who will do the right thing even when no one is looking.

Chapter 1: MEDICINE AS A MORAL ENDEAVOUR

> *"Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim -Aristotle, NE , (1947, p.308)*

The Death of Ivan Ilych recounts the story of a man living his last days preoccupied by the thought that he had not lived the successful life he thought he ought to have lived and that most of his life had been a lie. At one point, Ivan became sick and was advised to visit a famous physician, but the visit did not go as well as it should have. We are told that at the end of the visit, the patient said nothing, 'but rose, placed the doctor's fee on the table, and remarked with a sigh: We sick people probably often put inappropriate questions. But tell me, in general, is this complaint dangerous, or not?' (Tolstoy, 1967, p. 271). The facts are that when the physician first met the patient, 'he put on just the same air towards him as he himself put on towards an accused person.' (Tolstoy, 1967, p. 270). He assumed an air of distance and indifference and treated Ivan as a disease or a number while for Ivan,this illness was something that affected his inner being. His awareness of pain and mortality shattered his being. Yet, the famous physician ignored that part of him. The physician was a skilled renowned physician indeed, but something in him was wanting. This was precisely why Ivan could not be healed in his presence.

Ivan was sick and his physician-patient encounter suggested a clinical encounter that failed to promote what is needed for a good healing relationship. The patient was powerless and in need of help. He visited the physician who was careless, and treated him as a number. In

this chapter, I shall argue that medicine is a moral endeavour and hence, ethics[2] and virtues are vital for the making of a physician[3], let alone a fine one. It follows from this that medical schools need to educate students of medicine in ethics and virtues. I will argue that virtues have to be internalized and become second nature since this is when the ends of medicine will be met and the profession of medicine is safeguarded. In order to do so, I will begin by assuming that medicine is a moral enterprise and will consider the views of Edmund Pellegrino regarding the ends of medicine and provide a critique of them whenever I think that his arguments are inconsistent. I will also discuss the importance of trust in the physician-patient relationship and argue that trust is a quintessential part of this relationship which has been damaged in modern day medicine and which needs the development of the good character of the physician in order to regain its place and salvage the clinical encounter from a fatal breakdown.

1.1. Why Edmund Pellegrino?

Several thinkers have written about the ends of medicine. Brody and Miller, and Veatch, are three of the most prominent thinkers whose views will be presented, albeit briefly. Yet, focus will be placed on the views of Edmund Pellegrino precisely because Pellegrino is a physician who has spent a life time as a philosopher of medicine and this has a number of practical implications for medical ethics as a practical discipline. His philosophy is based on reflections on years of practice: he has interacted with patients and healthcare workers and has spent a considerable amount of time reflecting on the role of the healer from the perspective of a practicing physician. By doing this, he has managed to bridge the gap

[2] In this thesis, the terms "ethics" and "morals" will be used interchangeably.
[3] It is my contention that a physician deserves the name "physician" if and only if she is an ethical one and follows the appropriate norms of her profession. Otherwise, she is a dexterous and proficient skilled medical technician.

between theory and practice. His worries and research questions are the same ones I often reflected on while looking at how things are happening in practice: medicine is an art in addition to its being a science, that it is a moral enterprise, that medicine cannot do without the humanities and that what is needed mostly to safeguard medicine from an inevitable downfall amidst the rapidly developing scientific technology is the making of a humane physician. I largely share his views. Most importantly, Pellegrino's views are that of a person who, while writing about what ought to be the case, starts from a reflection on the realities of medicine and believes that we should be mindful of blind utopianism. Thus,one of the main strengths of his ideas lie in the fact that unlike several philosophers who simply philosophize theoretically, his ideas are actually based on real life practice. He worked with suffering patients, he held the stethoscope, he felt the vulnerability and the anguish, he experienced the duties and the tension and he reflected on this while *being* there. A philosopher who is simply speculating even if his arguments are strong ones, but ones made out of pure a priori analysis detached from the realities of everyday life is not more convincing than Pellegrino whose philosophical reflection was lived. We live in times when we cannot afford pure speculations and incantations, we want reflections based on facts and empirical findings and this is precisely what Pellegrino's thoughts offer. More importantly, this is a requisite characteristic of medical ethics, a branch of practical ethics which distinguish it from pure theoretical ethics and pure philosophy. So one cannot ask Pellegrino "how do you know?" because he can simply say "I've been there" instead of "I think so".

1.2. Medicine as a moral enterprise:

Let me begin with a true story: Mrs. A was ready for a normal vaginal delivery and everything was progressing smoothly. The attending physician, the resident and the student

in third year medical school were gathered around the patient. Suddenly, the attending physician asks the nurse to get a forceps and starts explaining to the resident the mechanism of using it and how a baby gets delivered by forceps. The student, sensitive to issues pertaining to ethics and the rights of patients, dared to ask the attending physician about the reason for resorting to a non-indicated forceps delivery. The reply was plain: the resident had never delivered by forceps and the attending physician wanted to teach him. This was, after all, a teaching hospital. Neither the mother nor the father had an idea of what was happening. After the procedure was over, the note on the medical chart indicated "normal vaginal delivery". This case raises the issue whether medicineis purely a scientific activity, one that can be isolated from ethical issues.

Regardless of the fact that both mother and newborn were exposed to medical risks that could have been avoided, several ethical issues arise. The one that baffled the student most was that this obstetrician had lectured them about ethics and the importance of putting the interest of patients first. Looking back at the old days of Hippocrates, Galen, Percival, Avicenna, Al Ruhawi, al Razi and others, medicine and ethics were inseparable whereas the modern day medical profession[4], it may be argued, is marked by an intellectual schizophrenia which is turning the Hippocratic Oath into a *hypocritic* oath. The case described above suggests that physicians who play the roles of models or archetypes to

[4] Generally speaking, a profession consists of a group of people who hold on to some form of high moral benchmark. They are accepted by the public as possessing a special kind of knowledge and a special kind of skill. The profession consists of an organized, educated and trained collection of people who are ready to exercise their knowledge and skills in the interest of others. A person who belongs to the profession of medicine is someone who, essentially, has been trained in the healing arts and has received a license to practice. Nowadays, one can argue that in addition to that, he should also be fully dedicated to the ethical principles and values of the medical profession and serve the internal ends of medicine (presented in this thesis). These characteristics, it is maintained, are universal and not context dependant. More will be said about this in the section on universalism and social constructionism.

students and who have taken the solemn oath and have pledged to protect life and relieve suffering are faltering and abusing a power that was bestowed upon them by virtue of their profession. By contrast, a number of authors including Jotterand (2003), Sulmasy (2006) and Pellegrino (2006) -among others- have argued that medicine is a moral endeavour. Medicine is inherently a moral enterprise because it is a profession that is grounded on the covenant of trust, is performed according to specific set of beliefs about what is right or wrong in medical behavior, adding to it the fact that, perhaps every judgment that a physician makes involves both facts and value judgments.Medicine is directed towards a healing relationship that requires moral accountability. Henceforth, a physician is morally and scientifically obligated to act in the best interests of the sick person and failing to do that, acting for self- interest and commercial gain, is failing to live up to the profession of medicine. What is moral is related to one's interactions with others. Physicians constantly interact with patients, families, other members of the healthcare team, and different social entities (insurance companies, officials, etc). In fact, the therapeutic relationship that marks the physician-patient relationship necessitates some sort of moral accountability that we do not see with the hairdresser, the shoemaker or the pilot. As such, while thinking of what she ought to do in a particular situation, the physician thinks in terms of values, virtues, morals and social dynamics. Although scientific considerations are important, they are not the sole considerations that matter. The hairdresser[5] interacts with people, yet, one does not normally consider hairdressing to be a moral enterprise[6]. There is a difference between the person who enters the hairdresser's shop asking for a new haircut for example, from one who presents to a clinic or an emergency department. The physician affects the patient in a

[5] Hairdressing is a business, the end of the hairdresser is to dress the hair of his client. He does not have the well being of the other (as an end in himself) in mind.

[6] One might argue that nursing and education are such enterprises. Education is particularly interesting as it is concerned with the selves of students in particular and with society at large. Teaching involves a moral action and educators are (or ought to be) moral agents.

way the hairdresser or the shoemaker does not as the physician's activities are entrenched in moral concerns. The duties of the hairdresser are to make sure that he cuts the hair of his "client" appropriately and perhaps creatively possibly to ensure that he uses a non-toxic shampoo, but he need not be concerned as to *why* the client wants a new haircut or hairdo (without contravening the moral conventions he is expected to follow which everyone in society ought to respect). On the other hand, the physician is bound by moral constraints: she has moral liberty to do only that which she has reason to believe will 'benefit' her patient. 'Benefit' in the special sense of the term as health is an essential good while a haircut is not. If she fails to do so, she has betrayed her part of the contract and might be blamed for it, which is not the case with the hairdresser. The blame facing the physician is a moral blame (attacking her skill and ethics/sense of justice). The blame facing the hairdresser who ends up doing a bad haircut is not a moral blame but a different kind of blame: It might be social, aesthetic or even simply an attack on his expertise. Although one can argue that just as patients trust physicians with their health, clients trust the hairdresser with their hair, yet, what really differentiates the two is that the physician is bound by the duty of beneficence (in the moral sense) while the hairdresser is not. At most, the hairdresser has to fulfill the demands of hiswork. Physicians see patients, do investigations, diagnose, prescribe, treat, do research and teach. Each and every one of these steps has an important ethical component to it.

The question that arises is which features of the profession of medicine are essential (part of its nature) and which are not and how do we tell which are which? Essentialism is generally defined as the belief in essences. Thus, essentialism entails that given entities have certain fixed properties that define them and make them what they are. These properties are not accidental characteristics; rather, they are a *must* in that the object possessing them cannot exist without them. For example, the property of being human is

an essential property that Socrates possesses. So what is (are) the essential property (ies) of the profession of medicine without which it ceases to be what it is? In an attempt at answering this question, physicians start listing a set of behaviors that people in other professions do not engage in, like for example "a physician deals with health and body while others do not", "in medicine, the patients will inform you of their most personal issues", "you do physical exams", etc. If an essential characteristic of an object is something that it "must" have, and without which it ceases to be what it is**,** then the essential characteristic(s) of medicine is not that easy to define. According to Sokol (2008, p. 1163) it is *love*. Sokol is a bit too optimistic. However, one can argue that what distinguishes medicine from other professions is that patients trust the physician with their lives. While one might argue that a passenger trusts a pilot with his life, this is not the essence of the passenger/pilot relationship. This is more of an accidental property as the trust happens to exist in this relationship but it could very well be lacking. He might trust an airline more than another because of a reputation it has but the reason he takes the trip with that airline is not because he entrusts it with his life but because he wants to reach to a certain destination. This trust comes in the second place. In medicine, this trust is primary and is essential to medicine and to the physician-patient relationship which is at the heart of the medical profession. However, one can imagine a situation where the medical profession is not trusted: misdiagnosis is one leading cause of trust erosion. Another leading cause of this distrust is the system itself: a JAMA article by Starfield (2000) reveals how the US healthcare system actually contributes to ill health. There are stories of physicians harvesting organs from homeless patients to give them to paying patients without the former's consent or without them knowing, others favouring some patients (private) over others (non paying). So the argument that "trust" is the essence of medicine seems to falter: It perhaps ought to be the essence, *may have been* the essence, but is no

longer. The problem with this last contention is that itseems to be saying thatessences change with time**.** But if that isso, does that still make them essences or do they become something else? Thisthesis is not about essences and their nature, and as such, no in depth discussion will be made about this issue, but it is important to note that trust (as will be shown later) is an essential aspect of the physician-patient relationship and without it the encounter falters in that it will not live up to the ends of medicine. This relationship is the heart of medicine and hence, trust is an essential characteristic of medicine. The fact that many things are happening that are tarnishing this essence does not mean that it is not a defining essence, but only mean that something wrong is taking place and needs to be redeemed. If a patient goes to a physician without trusting her something is missing in the medical relationship and the profession of medicine will have to be redefined. One might even wonder whether the encounter between the patient and the physician will take place to begin with. Even with medical mistakes, patients act on the convictionthat these happen in spite of the physician and are confident that the physician will do her utmost and will act having the best interest of the patient in mind.

Another essential characteristic that the profession of medicine has and that is inherent in the physician-patient relationship is that of empathy or profound appreciation of another's (the patient's) situation and point of view. One can even argue that what Sokol referred to as "love" (2008) is actually a deep sense of empathy that good physicians are capable of. The hairdresser, the body guard, the pilot can be skilledand all loving but they need not be empathetic. Empathy does not define a good pilot, a good body guard or a good hairdresser. It, however, is a defining characteristic of the good physician because health is about the personal narrative of the patient, not only the disease. A physician (as opposed to a skilled practitioner) treats the illness not only the disease. She gets in touch with the humanity of the ill person unlike the hairdresser. A non empathetic physicianis reduced to

the status of a skilled practitioner.Other characteristics that might characterize the profession of medicine, like it being based on a fiduciary relationship, centered on confidentiality, committed to scientific knowledge are equally essential but are not specifically unique to the profession of medicine. One can go on discussing the essential traits of what constitutes the profession of medicine however, suffice it to say, for the sake of this dissertation, that the above mentioned essential characteristics make of the profession of medicine a unique profession, with a unique oath and this is precisely why neophyte physicians need to be trained and educated in the appropriate virtues in order to become "physicians" and not only skilled technicians or practitioners. The duties of a physician are dictated by the internal ends of the profession[7] and they ought not violate the dictates of morality, hence the presence of oaths and codes. Medicine is a moral enterprise founded on the covenant of the physician/patient relationship. It is not a business or a commodity that is subject to the whims of the market and even if it actually is, it ought not be. Hence, it must be guided by commitments to what is morally right and essentially good, not just by what is necessary in academic or economic undertakings. As such, it invokes ethical principles and must apply them. Medical acts ought to be moral practices, geared towards the benefit of the patient who is viewed as an end in himself. Values enter

[7] Generally, a profession refers to an occupation which professes to have a knowledge system in a special area such as health when it comes to the profession of medicine. According to Robert Young, the concept of profession refers to a category that some occupations reach while others do not. Hence, a profession has certain characteristics and these have certain consequences for the people who have professional status and the establishments where they work. Young presents six such implications: they spend most of their time in that occupation; their occupation is a *calling*, they are set aside by signs, symbols and rewards; their practice depends on special knowledge or skill; they are expected to show a service orientation; they benefit from an autonomy limited only by their professional responsibility (1987, p. 12). The fact remains that it is not easy to give a definition of the concept "profession". Yet, as Calman points out, "it is likely to have some or all of the following characteristics. It is a vocation or calling and implies service to others; it has a distinctive knowledge base which is kept up to date; it determines its own standards and sets its own examinations; it has a special relationship with those whom it serves-patients, clients; it has particular ethical principles-the ethical base; it is self regulating and is accountable to patients and to the profession itself." (1994, p. 1140).

in almost every decision that a physician makes and one can argue that medicine imposes collective responsibilities on all its practitioners. On this view the quintessential moral attribute stems from a conception of the ends of medicine. We therefore need to ask ourselves: what is the nature of medicine, and what are its ends?

1.3 Edmund Pellegrino and the Ends of Medicine:

In what follows, I will begin by presenting some of the major ideas of Pellegrino. Emphasis will be placed on the ideas he presented in his "The Internal Morality of Clinical Medicine: A Paradigm Shift for the Ethics of the Healing Professions" (2001A). I will then raise a few questions regarding some of his views that I find rather controversial, more precisely, what I consider as internal inconsistencies in some of his ideas. I will also attempt to answer them from the point of view of Pellegrino himself. When this is not possible, an alternative solution in line with Pellegrino's thought will be provided.

Pellegrino gave a very thorough account of the history of medicine. He wrote: "In the earliest times and still in primitive societies, medicine is identified with religion and magic. In the Greek era, medicine first merged with philosophy as well as religion. Aristotle's treatise *On Ancient Medicine* sharply delineated it as a practical endeavour separate from philosophical speculation. Varro, the Roman encyclopedist, classified medicine with the humanities." (1979, pp: 189-90) So what is medicine: an art or a science? To say that medicine is not a science is ridiculous. After all, medicine deals with clinical problems, uses research methods and experimental studies, works with hypotheses and is often

evidence-based just like other sciences[8]. While medicine is a science, it is also an art, a skill acquired by experience and observation. Indeed physicians come to interact with what is most sensitive in the lives of the person, embark on different kinds of activities, which are not scientific, and are essential to the practice of medicine as a science. They look after the sick, reassure, communicate, and listen to him and often advocate for, and try to understand, the patient. The art of medicine is that which allows a physician to explain to family members why is it that the science of medicine did not yield the results they hoped for (for example, when a much hoped for surgery failed or yielded serious complications). It is the art of medicine which helps the physician deal with a patient who was rendered emotionally frail because of his illness. It is this very same art that allows the physician to break bad news, to educate patients and families about the importance of a procedure when they were initially in total refusal of it, to help them cope with denials and to comfort family members who lost a dear one. It is this art that allows the patient to return to the same physician for consultations although he has not been compliant but he knows that the physician will handle him with care and will deal with him appropriately.To put it simply, the art of medicine is that which allows the physician to take care of the patient and of the disease, which, in the profession of medicine, should be inseparable. As Katz puts it, "A medical man was an artist in his ministrations to the ill" (1951, p. 398)Unlike other basic sciences, it has an extra dimension that makes of it a hybrid discipline: Medicine implies that there is a *physician who is dealing directly with living people* and this in itself marks one of its major departures from sciences like biology, physics or chemistry- as the activities of the 'pure' sciences will only impact eventually on people.

[8] Pellegrino and Thomasma speak of medicine as a "science of practice, a set of principles governing the art of healing" (1981, p. 7) which combines knowledge and skill about healing.

This brings us to the second feature of medicine, namely humanism. Pellegrino asserts that the notion of humanism encompasses a cognitive as well as an affective element: the first one is related to the physician as a human being, member of a society and possessor of ideas and modes of expression; while the other is related to the physician and her feelings and attitudes toward her patients qua persons undergoing the "existential trials of illness" (1979, p. 157).

This second characteristic of a physician cannot be overestimated. Several studies have revealed humanism as an important, albeit lacking, character trait in modern day physicians (Arawi, 2009; Bazrafkan et al., 2008;Wensing et al., 1998; Caroll et al., 1998). This image of medicine as belonging to the sciences and to the arts has bearing on education and what came to be known as the 'philosophy of medicine'[9]. Thus, later on, Pellegrino wrote one of his most famous statements defining medicine as "the most humane of the sciences, the most empiric of arts, and the most scientific of humanities" (1979, p. 17) Notwithstanding, back in 1969, he had a presentiment: "Medicine, posited between the sciences and the humanities, is one of man's most potent instruments of enlarging both his individual and his social being. To serve this purpose, medicine must respond to the current challenges by creating a new unity of its scientific, ethical and social perspectives. If it does, it might become the genius of that new humanism the world so desperately needs to make technology ever the servant of human purpose" (Pellegrino, 1969, p. 55). It follows from this conception of the nature and function of medicine that that the profession of medicine and its practitioners exist to help patients and that medicine is a goal-directed activity conducted by the health-care practitioner who has a healing and therapeutic role to play. This activity is mainly related to patient care and in this sense, the

[9] As defined by Pellegrino, the philosophy of medicine "consists in a critical reflection on the matter of medicine- on the content, method, concepts and presuppositions peculiar to medicine *as medicine*." (1998, p. 325)

welfare and interests of the patient become the outcome the healthcare practitioner is supposed to bring about. Thus, while the sculptor's goal is the production of a statue for its creative worth, the goal of a physician is delineated by the interests of the patient. Medicine is a goal-directed activity which aims towards something that is external to it and outside the confines of the personal interests of the physician herself. If the ends[10] of this activity are not achieved, the activity itself becomes meaningless.

To talk about the ends of medicine, certain terms cannot be ignored. Such terms are medicine, health, sickness, patients, and doctors. Medicine (from the Latin *medicus*: helper who carried out the art of curing) is generally thought of when there is a person who is sick and would like to have his health restored. In order to achieve this goal, willingly or not, he resorts to a physician. Health allows a person to pursue, *ceteris paribus*, his rational plan of life. A patient (from the Latin *patior*- "to suffer"-[11] in the sense of suffering pain and being capable of enduring) is a person who is vulnerable, whose autonomy has somehow

[10] Indeed there exists what I would like to call the "wrong" goals of medicine. Such goals are becoming rampant these days. For example, if one asks students of medicine about the reason why they join the profession of medicine, they would cite reasons like: to gain prestige or to make money. Such are examples of "wrong ends". Ends like these distort the profession of medicine and render it more like a business. They undermine the very nature of this profession.

[11] Pellegrino rightly argues that suffering cannot be understood solely from the physician's perspective. I argue that this is one important assumption in his philosophy for if a physician were to assume that she knows what the suffering is for a patient, she will not be able to understand the personal experience of the patient as she sees it just as it is often wrong to assume that the physician can know what the quality of life is for the patient from that patient's perspective. We often tell our students of medicine how important it is to put themselves on the other end of the stethoscope knowing that this is not an easy thing to do. Often the person's view of suffering involves his existential being and personal values. Patients must be asked what suffering consists for them. The results might be surprising for the health-care practitioner as suffering can have a social, psychological and spiritual dimension, not only a physiological one. Indeed, an entire new trend in medical ethics has emerged entitled *narrative medicine* which takes account of the lived experience of the patient precisely because the particulars that the patient lives are often unknown to the physician and relevant to the experience of illness. Thus, the notion of suffering (with what is personal in it) cannot be separated from the ends of medicine.

been reduced and is in need of the physician[12]. The latter is in a situation of power[13] since she is the one who is sought in the hope of helping the weak and the vulnerable and who, purportedly, has the knowledge and the skill to heal. The profession of medicine is based on the clinical encounter between patient and physician (hence the importance of the physician-patient relationship). Consequently, Pellegrino notes in most of his writings and lectures that the main ends of medicine have to do with the activity that aims at healing the patient and restoring his health when this is possible.[14] When it is not possible, this activity has to be directed to relieving the patient's pain.

Pellegrino also argues that morality is internal to the practice of medicine. In his "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions" (2001A), he traces back the concept of an internal morality of the professions to Fuller who used it in his philosophy of Law and argues that it was later modified by John Ladd who spoke of an internal morality of medicine to mean a "body of norms binding on physicians by virtue of membership in the profession of medicine" (2001A, p. 561). However, Pellegrino does say that his own conception is closer to that of Kass which was teleologically constructed (2001A, p. 562). He himself differentiates between what he calls the ends "external" to medicine and the ends "internal" to it (for example, healing a sick patient is an end that is internal to medicine whilst receiving

[12] Interestingly, in Arabic two words are used to denote the term physician: *hakim* (wise) and *tabib* (doctor). The first one is the one that is mostly used both in spoken and in written Arabic. It denotes the character of the traditional physician which adds to the duties of the doctor certain moral obligations in addition to her technical expertise and skill.

[13] There are several instances where this power can and has been abused. An interesting discussion of the relationship of power to medical ethics can be found in Brody, H. (1993) *The Healer's Power*, New Haven, Yale University Press.

[14] Some might argue that medicine's aim is solely the restoration of the autonomy of the patient. It is my contention that this is a controversial claim for a number of reasons the most important of which being that there is quite a considerable number of patients having suffered an irreversible loss of autonomy (Alzheimer's patients, patients with PVS, or pediatric patients). Does this mean that medicine's aim will not be fulfilled with this sample of patients?

payment is an external end (2001 A, pp. 559-79). Put simply, the ends of medicine are *internal* to the profession[15] and can be derived from a correct understanding of the ends of medicine as a practice. He argues that the right norms of the medical practice are internal to the profession and henceforth can be derived from the correct discernment of the ends of medicine. External goods are contingently connected to the practice of medicine. They are attached to it accidentally and as such one can obtain them from other means (examples would be power, wealth, and prestige). Any external end which is not compatible with the internal ones is an intruder to the profession and cannot be accepted as standard practice of the good physician. In other words, and in quite an Aristotelian approach which ties the *good* to the *end*, once we clearly identify what the ends of medicine are, we can easily deduce the characteristics of a good physician. Just like a good pianist is one who plays the piano well, a good physician is one who performs her function well by exhibiting well the (internal) ends of medicine. Thus, Pellegrino distinguishes between the use of the words *end* (telos) which are internal to medicine (like curing, caring, and healing) and *goal* (purpose) which are external (like torturing prisoners, participating in executions, performing abortions)[16]. This is not to say that goals are, by definition, morally

[15] Pellegrino puts a lot of emphasis on the word 'profession' as a public declaration and hence a promise to perform the duties of a physician.

[16] One might wonder whether there is such a thing as a 'bad physician' to begin with or whether the term physician should be dropped from a health-care practitioner who performs bad actions not in line with the internal ends of medicine. The term 'good physician' seems to be redundant just as the term 'bad physician' seems to be an oxymoron. The point is that a physician is someone who, by definition, should have the best interest of her patient in mind, serve the internal ends of medicine, honor her profession and is selfless when it comes to her profession. A physician should be virtuous at least to a minimum because one cannot be virtuous only in part. Students of medicine get an MD and this qualifies them to become skilled technicians unless they have that extra something that makes them a physician (which an MD should give them to begin with but it does not, this is why there is a need to re-evaluate the educational system and to ask for virtues in the education of the neophyte physician).
That extra something is what makes the medical student aim at serving the internal ends of medicine. Later on there will be mention of core virtues without which a physician is nothing but a "skilled technician" or what people call "bad doctor". There is no such thing

undesirable. For example, abortion can serve the internal ends of medicine when it is done to save the life of the mother. One can even argue that being part of executions aims at reducing the amount of suffering which can be viewed as one of the aims of medicine. As Pellegrino mentions, there are times when goals coincide with the internal ends of medicine, yet, they remain external to the practice.Thus, to be a health-care practitioner, such as a physician, one has to acknowledge the internal ends of medicine which are traditionally to cure, care and to help (1999, p. 57) and Pellegrino emphasizes that it is "healing which is specific to this patient, not healing as an end" (1999, p. 63). Henceforth, one can conclude that to Pellegrino, just as it is to others, medicine is much more than simply 'diagnose and treat'. It is defined as "knowledge based and directed by an architectonic principle – healing or helping a sick person become whole again." (1999, p. 63). As he stated with Thomasma, "the ends of medicine are ultimately the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease, or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability." (1993, pp. 52-53).

Almost the same idea is echoed by Sugarman and Sulmasy (2001, pp. 78-79): "Medicine exists because humans become ill and want to heal, ameliorate, cure, or prevent this universal human frailty". They add that the physician has to serve not only the patient's good but the patient's "perception of good - material, emotional or spiritual." (1993, p. 53). We see the same idea a few years later when Pellegrino says: "the optimal end of healing is the good of the whole person-physical, emotional, and spiritual. The physician, manifestly, is no expert in every dimension. He or she, however, should be alert to the patient'sneeds in each sphere, do what is within his or her capabilities and work with others in the health

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as "bad doctor" since a doctor, or preferably, a physician, either is good or is not. He cannot be bad. It is like having a thing and its opposite at the same time.

care team to come as close as clinical reality permits to meeting the several levels contained in the idea of the good of the patient." (2001 A, p. 569) As he later says, "The end of healing is the good of the whole person" (2005 B, p. 25). Brody and Miller (1998, pp.386-99) equally talk about the internal morality of medicine which they define in terms of the "goals of clinical medicine" (derived from the concept of medicine) and argue that there should be a set of duties which constrain medical practice in the pursuit of these goals. More will be said about this later.

Interestingly though, and in another article in which he talks about the duties of the physicians, Pellegrino states that "some things ought never to be done" (2005, p. 469) in the profession of medicine. He argues that certain moral absolutes are inherent in the physician-patient relationship and are necessary for the attainment of the good of the patient (which is ultimately the *telos* of the relationship). Pellegrino refers to Aristotle's contention that "certain acts were always wrong and should never be done, e.g. murder, adultery, lying, stealing" (2005, p. 472). Thus, for him, "Clinical moral absolutes are norms and mandates that must never be abrogated because their abrogation vitiates the healing ends of medicine" (2005, p. 475). These absolutes which Pellegrino believes are essential to medicine's end are: to act for the good of the patient, not to kill, to keep one's promises, to protect the dignity of the patient, not to lie, and to avoid complicity with evil. However interesting this idea is, it is quite a controversial one. In what will follow I will raise a few questions regarding some of the Pellegrinian views presented above. I will try to respond to them from the point of view of Pellegrino himself. When this is not possible, an attempt will be made at providing an alternative theory which is in line with the general framework of Pellegrino.

1.3.1. The Ends of Clinical Medicine:

Pellegrino argues that the ends of medicine have to do with the activity that aims at healing the patient and restoring his health when this is possible and that the ends of medicine should aim towards the good of the patient without ignoring the patient's perceptions of what his good is. According to Veatch, Pellegrino's belief that the end of medicine are non controversial is a false view for the very simple reason that the goals of medicine have changed (2001, p. 630). Veatch argues that in the middle of the 20th century physicians were committed to the preservation of life. With time, this was followed by a commitment to prolong life, followed by the goals of curing disease and relieving suffering and more recently, the prevention of disease and the promotion of health. He also maintainsthat these goals have competing claims and we often find ourselves in controversial situations (2001, p. 631). However, all the four goals highlighted by Veatch have the good of the patient as the ultimate end and the promotion of health as the sole aim and as such do not contradict Pellegrino's view of the end of medicine. Veatch who argues for an "external morality" of medicine, recounts the dilemma of *Internalsville*[17] to show that the ends of medicine are closely tied to the ends of living and social functioning. He asks: "Assuming that Pellegrino has it right when he says that the end of medicine is to promote the health or healing of the patient, does castration serve this objective in Internalsville or does it thwart it?" (2001, p. 633) only to show that it thwarts it. His argument is that deciding which view of medicine to follow requires a reflection upon basic religious, philosophical and cultural norms (2001, p. 632). Yet, one can contend that the role of the physician and the practice of medicine itself have limits and these limits are

[17] Physicians in a unique society are requested to help castrate a special class of religious singers whose role in that society is highly valuable. Only physicians can perform this castration in a healthy and painless way. *If* one were to concede that *Internalsville* and its cultural practice and beliefs are worth maintaining, then one can argue that the assistance of these physicians is moral. Hence, the ends of medicine are socially constructed. I will return to this idea of social construction shortly.

set by the internal nature of medicine. Although one can argue that a physician who agrees to reduce the size of the breast of a woman only to allow her to improve her golf swing (or social status) is serving the ends of medicine, one can contend that the ends served are not the "internal ends" of the profession since the physician (ideally) violates the body only to heal it. When the opposite happens, one will have to start looking for another definition of medicine and its ends. Although the patient's perceptions are important, the physician cannot be forced to act against her professional conscience precisely because the key relevant value to Pellegrino is beneficence[18]. It also becomes rather questionable to assert that it is morally required that a physician who practices in the Kingdom of Saudi Arabia changes her behavior when practicing in the UK or China on the pretext that medicine's morality is externally derived and tied to social functioning. Would we be not creating morally schizophrenic physicians if we do so? It remains a fact that to many, particularly in the US, autonomy is the most valued principle in contemporary medicine. As such, if the patient wishes to have her breasts reduced (with all the risks involved) then, the physician, although she has the duty to warn her, has two options: either to respect the choice of the patient and go ahead with the operation or refer her to another physician who is willing to do it.

In general, putting too much weight on a patient's autonomy might be problematic in many respects. For one, one might end up by taking the easy way out by simply resorting to the decision of the patient, which is to say, giving up on the patient under the pretext of his autonomy. Another problem would be that the patient's good and the patient's perception of his good may be different. According to Pellegrino, "what is medically 'good' simply on grounds of physiological effectiveness may not be 'good', if it violates higher levels of good, like the patient's good as he perceives that good. This perceived good is the second

[18] What counts as beneficence is, for Pellegrino, that which is oriented towards healing and acting for the good of the patient.

level of patient good" (2001A , p. 569)[19]. He later on defines this good as respecting the patients' "personal preferences, choices and values, and the kind of life he wants to live, the balance he strikes between the benefit and burdens of the proposed intervention" (2001A, p. 569) acknowledging that they are "unique for every patient and cannot be defined by the physician, the family or anyone else" (2001 A, p. 569). For Pellegrino, the patient's perceptions of the good supersede the patient's medical good for "to serve the good as perceived by the patient, the medical good must be placed within the context of *this* patient's life-plans and life situations"(2001A, p. 569). This, however, seems controversial: If the medical good has to account for the patient's perception of his good, then the physician will often find herself having to respect the wishes of her patient even if this were against the medical good of the patient and the beliefs of the physician and/or her medical judgment. So where do we draw the line? Pellegrino though finds a way out of this conundrum. He argues that the patient's good is superseded by the "good for humans" (more will be said about this below) and that the physician has a conception of the good which may differ from the patient's. In this case, the physician is not forced to cooperate with the patient and can simply tell him that she is not the right doctor for him: "[w]hen the patient's and physician's values are sharply at variance, the physician should decline to enter the relationship or withdraw from it graciously, with candor, and without recrimination" (Pellegrino, 1993, p. 76). The bottom line is that the inherent (absolute) dignity of the patient forbids the physician from imposing her concept of the good on the patient at any of the four levels—except in the case of medical good in an emergency.

[19] Pellegrino speaks of four levels of good "[i]n each profession, the four components of the patient's good are arranged in lexical and hierarchical order. The spiritual good takes precedence over all, followed, in descending order, by the good for humans, the personal evaluation of the good, and, at the lowest level, the technical good specific to each profession. Moral decisions in the course of professional activities are right if they conform to the techne of each profession at the first level. But to be good, they must conform at the other three levels as well." (2001, p. 575)

Indeed, Pellegrino is aware of the problematic raised by emphasizing the importance of patient's perceptions of the good. He elaborates that the physician is not obliged to do whatever the patient defines as good because this would make the "patient's perception of the good " dominant over all other goods. It would make patient preference morally and lexically superior to the medical good, the good for humans, and the spiritual good" (2001 A. p. 571) which is not what ought to be the case. It remains true that it is not clear how deliberations happen and how the conflict between the levels of the good is solved. Yet, one solution would be to rely on the practical wisdom of the physician, to resort to the "rational good" explained below, or to have a form of *prima facie* good à la Ross.

One should also note that, for many physicians, the ends of medicine are different. They vary from prevention and healing of illness, to improving health, prolonging life, and giving hope to serving the best interest of the patient. The Hastings Report on the Goals of Medicine (1996) refers to five major goals, namely, promoting health, reducing certain kinds of pain and suffering, fighting disease and injury, advancing the quality of life and saving and prolonging life. In line with the Report, Pellegrino was aware that redefining the end of medicine will become the central problem in the philosophy of medicine (2005 B) and asks whether physicians should be "healers or servants of societal good, businesspeople, entrepreneurs, bureaucrats, scientists" (2005 B, p. 21) or something else. To him, the main ends of medicine have to do with the activity that aims at healing the patient and restoring his health when this is possible. This is the end of medicine at its core in the sense that there might be some other peripheral ends that can be a function of culture and/or time. But the core ends are, and indeed ought to be, unchangeable. More will be said about this later on. For those who argue that the ends of medicine ought to be the restoration of autonomy, one can argue that Pellegrino's view is in line with that view

also (of course, assuming that it is a patient whose autonomy we can restore). Restoring the health of the patient is restoring his autonomy that was initially fractured by the fact of illness. Add to this that the second level of the good which will be detailed a little more below, honors autonomy and Pellegrino argues that this level of the good supersedes the patient's perception of the good.

Nevertheless, there remains the issue of patients who have autonomous requests for abortion or euthanasia. Pellegrino is a conservative on abortion and euthanasia and believes that autonomy can be rightly limited when there is a question of taking life away. Such requests will not be honored by Pellegrino because they do not respect the "spiritual good" and because doctors must not kill. Pellegrino would not allow such acts because he argues from a catholic standpoint. The Church's teaching about euthanasia (labeled murder) has been straightforward: it is wrong regardless of whether the intention is relieving suffering or something else and regardless of the circumstances. According to the late John Paul II, "euthanasia is an attack on life that no human authority can justify, because the life of an innocent person is an indispensable good" (1988). The same idea is reaffirmed by Pope Benedict who stressed "the firm and constant ethical condemnation of all forms of direct euthanasia, in keeping with the centuries-long teaching of the Church" (2008). This is so because euthanasia violates the love and justice humans owe to God and man. Life is a gift from God and one has no right to intentionally take it away. This argument, however, might very well be accepted by Catholics, Christians in general, Muslims, perhaps monotheists, etc. but need not be accepted by those who are none of the above. In addition, one can argue that there is some discrepancy in Pellegrino's argument because respecting the will of the patient and his autonomy logically and necessarily entails respecting his advance directive, living will or wish for euthanasia and/or abortion. Persons have a fundamental human right to make personal choices about matters related to

life and death. Euthanasia and abortion (discussed below) are thought of as part of a continuum, all being means of exercising one's freedom of choice and "right to die". In 1991, a 45 year old leukemic patient, Diane, asked Dr. Timothy Quill (1991) to give her a barbiturates prescription which will allow her to put an end to her pain and misery when the time comes. To many, Quill was acting in the best interest of Diane and respected her rights. He was actually acquitted although physician assisted suicide was forbidden in the State of New York. An autonomous being has the right to choose and this right has to be respected, even to the point of indifference as to whether this choice is religiously right or wrong. Pellegrino cannot have it both ways. Although he would argue that such a patient will have to find another physician, yet this is morally worrisome for it is a form of abandoning the patient when the patient needs the physician the most and betrays a long established physician-patient relationship. Now to go back to the question raised above: Are medicine's ends universal or are they socially constructed?

1.4. Towards a Combined View of the Ends of Medicine:

In what follows, I argue that the ends of medicine are neither solely universal like Pellegrino argues nor are they simply socially constructed. Rather, it is my contention that the ends of medicine are universal in the sense that they operate within a universal framework but that they are also socially constructed in that they are liable to change and evolve depending on the society and the times. Having said that, it is important to note that these core values may occasionally conflict and when this happens, the physician will have to use her practical wisdom to decide what her actual duties of the case are.One of the important issues that arise regarding the ends of medicine previously discussed is whether these ends are universal (applying to all given their human nature) or socially constructed. One is tempted to maintain that if they are universal, then there are certain core traits and

core values that students of medicine should be taught so that they can rightly serve the ends of medicine and that if these ends are socially constructed, then the question of such core traits, although they might still hold, may become less stringent and be replaced by something more culturally relative. I beg to differ. Although a universalist view of the ends of medicine would entail the importance of teaching core values and traits to students of medicine, the same applies even if one believes that the ends of medicine are socially constructed. Because medicine is a moral endeavour founded on a covenant of trust and operates within a framework of right and wrong as elaborated earlier on,[20] one can say that, *ceteris paribus*, some things ought not be done in the practice of medicine without violating the internal ends of the profession.

Given the nature of the profession, medicine's internal end lies in the good of the person seeking help and this is, universally, healing and helping regardless of time and place[21]. The ends of medicine embody a reaction to a universal human experience which is illness. The fact that medicine has internal ends to it highlights this universal dimension even more: these ends transcend the limits of the *here* and *now* precisely because they are a function of the clinical encounter and the existential nature of illness and what it brings about. They defy space and time because sickness is a universal plight and the patient has entrusted[22] the physician with his health. But these internal ends, I argue, function as moral boundaries that function as a universal framework in that they apply to all physicians everywhere and at all times. Social constructions exist and operate within the framework. The particular circumstances, individual differences and contexts of an illness may vary; yet, the nature of the experience itself is the common denominator. This experience and the

[20] See chapter 1, page 6, section 1.2.
[21] Physicians might have additional, secondary or external ends in their pursuit of medicine, yet, none of these ends define medicine's primary or internal end.
[22] More will be said about this later on in this chapter.

existential crisis it creates are reflected in the numerous codes of medical ethics across history. Codes from China, Japan, India, Ancient Greece and Rome, codes from the Middle Ages, to the eighteenth, nineteenth, twentieth and current century are different because they reflect different societies and cultures but have common guidelines which call for the healing of the sick as being the primary goal of the medical profession. These common guidelines reflect the moral boundaries and the universal nature of these ends. They are the framework within which the social constructions operate. Needless to say that codes are born situationally and contextually. They do not come into being *ex-nihilo*. Medicine has its purpose and physicians have their integrity. This purpose and this integrity cannot, and indeed should not, be derived from something external to the profession of medicine. If this were to happen, it is the end of the profession of medicine as we know it: medicine becomes the slave of external social forces that can very easily damage its reputation and its raison-d'être. Yet, one cannot ignore the fact that societal values and culture affect the physician and the profession: to begin with, everyday relationships among human beings are socially constructed. What is accepted in one society often is not in another. I am not advocating cultural relativism; rathersimply stating an historical fact. The same applies to the physician-patient encounter. Certain societies dictate that only a female physician examines a female patient except in cases of dire emergencies and lack of female physicians. In some cultures, it is acceptable, indeed required, that physicians be honest and upfront with their patients when it comes to diagnosis and prognosis, while in others, this is seen as utter insensitiveness and lack of moral decorum[23]. In certain cultures, pregnancies of unmarried women were terminated, in other cultures, the female is killed as this is considered a breach of honor[24]. Certain rural areas refuse to believe that an X-ray or MRI is enough and insist on a physical exam. Some rely on insurance and state money for

[23] These differences existed in ancient times as well.
[24] This is why in certain cultures physicians often debate the morality of hymenoplasty.

treatment; others still rely on family and friends. Indeed, one can even argue that what is counted as a malady may vary over time and can be subject to differing construals. Wildes (2001), perhaps correctly, argues that one cannot ignore the social dimension of medicine. He proposed a philosophy of medicine that was built on the idea that medicine is socially constructed. In other words, medicine is practiced in a certain social or cultural context which cannot be ignored. Pellegrino agrees with him that medicine is practiced in social or cultural contexts, yet denies "that this entails social construction as the method for defining the ends or goals of medicine." (2001B, p.177) For Pellegrino, observing and discovering the fact that medicine is practiced within a social context, as Wildes does, means that one can derive the meaning of medicine from the social context. This is not the case, he argues, because "[m]edicine comes into existence in the clinical encounters or in public health when knowledge of the sciences basic to medicine is employed for a specific end–i.e., for the cure, or containment, of illness in humans and society" (Wildes, 2001, p. 77). The main problem with Pellegrino's closed universalist view is the fact that he distinguishes medicine from other professions by the fact that it is centered on the encounter of the physician with the individual patient (and he derives the essence of medicine from this one-to-one encounter). The fact is that contemporary clinical encounter is far from being a one-to-one encounter. Other physicians and members of the health care team are present, the insurance company is present (albeit in different from), so is the state, legislators, the hospital administration, and others (more will be said about this issue shortly). Social structures make this encounter achievable. Even disease is socially constructed in the sense of how social meaning is attached to the underlying biological condition (for example, in certain cultures, STDs, AIDS, mental illnesses, and syphilis are stigmatized and even this stigma can change over time[25]. This has repercussions on the pronouncing of illness,

[25] See Conrad, P. and Barker, K (2010) 'The social construction of illness', *The Journal of*

access to treatment, as well as social ramifications). This is an example of how medicine is affected by the values of the culture in which it is to be found. Pellegrino sees medicine as beyond culture, which, to the reader, can be seen like a "metaphysication of medicine" if one can use the word. To Pellegrino, social construction allows for some distorted forms of medicine (and medical ethics) like the ones that happened under the German National Socialism, Stalinist Russia and other regimes. A socially constructed philosophy of medicine would be foreign to the ends of medicine. Yet, one can argue that what was done under these regimes was wrong and that what the physicians of these regimes did was failing to honor the moral boundaries of medicine. Thus, the burden of proof falls upon those who failed to do what is right.

Now why ought we to accept Pellegrino's essentialist view of the ends of medicine and not Brody's and Miller's evolutionary view? Brody and Miller (2001, pp. 581-599) argue that Pellegrino's conception is an "essentialist"[26] one in that he reduces the goals and ends of medicine to Platonic forms which are "historically unchanging" (p. 584). They disagree with Pellegrino because they distrust the Platonic forms and they think that his conception is essentially a conservative one. As such, they present what they call an "evolutionary conception of the internal morality of medicine" (p. 585) which is an outcome of a dialectic between essentialism and social constructivism. They do not derive the internal morality of medicine from a constant conception of the practice of medicine which yields a single set of goals and ends that applies at all times and in all places. Rather, to them, the nature of medicine and its internal norms are evolving and this evolution occurs in dialogue with the adjoining culture, such that the goals of medicine develop alongside with

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Health and Social Behavior, vol.51, pp. S67-S79.

[26] Brody and Miller argue that Pellegrino sees this as the only possible substitute to a *socialist constructionist* conception of medicine according to which "medicine and its morality can be reinvented more or less at whim whenever external social forces pushed it in new directions" (2001, p. 585).

human history and culture. Consequently, medicine may, from time to time, be reconceptualized and can thus assimilate new behaviors and duties on the part of physicians. Contemplating the traditional goals of medicine leads Brody and Miller to conclude that there is a "historical continuity" or evolution to the goals of medicine. This evolution can for example include the participation of some of physicians in helping some of their terminally ill patients end their lives through physician assisted suicide or euthanasia. It is my contention that while this evolutionary view seems appealing to a moral pluralist, it does not really hold without affecting the nature of the profession of medicine in its quintessence. So in a way, one can argue for a fusion of the essentialist and the evolutionary theory.

In what follows, an amendment to the evolutionary view which takes account of Pellegrino's essentialist conception will be offered. Although one cannot deny the fact that the goals of medicine and the duties of physicians are affected by the culture and by the times, one can maintain that the evolutionary conception does not necessarily do away with the essentialist position presented by Pellegrino: New goals and new duties do arise[27] as a result of context and developments (after all, physicians in ancient time did not have to worry about issues resulting from IVF, stem cell research or cloning precisely because such technologies were non-existent). The contention being made here is that there are *core*[28] duties and *core* goals that remain unchanged regardless of time and culture (they are static) and that these core duties and goals are part of the internal morality of medicine and they define the profession of medicine. There is an unchanging crucial core of medical

[27] One wonders whether there are any goals and duties that get dropped. The ends of medicine have always been the same, only, with the advancement of modern technology new goals are added. Practically, some duties have been dropped. For example, physicians often omit physical examinations and send their patients directly to the X-Ray machine. But whether this should be the case is another matter altogether.

[28] Basic, essential and unchanging

morality surrounded by a periphery that is subject to change through give and take and dialogue with the neighboring culture, society and times. Such peripheral[29] goals may serve purposes other than healing (example of what these might include can be elective cosmetic surgery, participation in interrogation, fertility enhancement, etc). What is to belong to the periphery (the dynamic goals) is not an easy thing to decide and will have to be a product of deliberation by concerned thinkers and ethicists. But it is essential that throughout these deliberations, core values such as the healing of the patient and the integrity of the physician should not be compromised. The relative size of each is another issue altogether. So, Pellegrino did have a point in arguing that medicine has certain goals and duties that are internal to it and these are core *goals* and *core duties* which are not a function of culture and time. However, the problem with his theory lies in that he left it at that and failed to see that medicine cannot remain blind to social and cultural developments particularly since the needs of patients are often a function of such developments. On the practical level, this taking account of social changes and developments is seen in the amendments and developments of new codes of medical ethics and new versions of the Hippocratic oaths. One cannot turn a blind eye to the fact that the social fabric is powerful and medicine is about people and societies. This fact alone makes part of medicine a function of people and societies. However, the amendment I am offering is not immune from criticism: One can argue that there is no essential core (be it in terms of goals or duties) that is impervious to socially constructed changes and that whatever remained from history remained as a matter of contingency but might very likely change with time and cultural/social interaction. A reply to this would be that something 'requires' that the core duties/goals remain unchanged and that thing is inherent in the nature of the profession itself which is closely tied to its goals. Core goals and core duties will necessarily have to

[29]A function of time and place. They vary depending on context, culture, evolution, technological development, etc.

remain unchanged or else, if they change, medicine will cease being what it is and will become something else. This thing makes its *essence* so to speak.

Other *evolutionary ends* are bound to arise with time precisely because medical technology is developing at a rapid pace and new issues are emerging in the clinical encounter. But *core ends* (beneficence is an example) are such that they can only be trumped by reasons that serve the ends of medicine, or else, medicine will cease to be what it essentially is: a healing profession. They are the basis around which everything else revolves and the stable core that allows trust in the physician to thrive and develop. Yet, there might arise situations when in order to benefit the patient, physicians find themselves sliding towards what can be viewed as harming the patient (morphine used to relieve the suffering of a patient at the end of life can also hasten death by suppressing his respiratory system. In such cases, the principle of double effect helps one make decisions). However, the appeal to phronesis is required to resolve any conflict that might arise between different core ends.

1.5. Needs, Perceptions, and The Ends of Medicine:

According to Pellegrino, "the optimal end of healing is the good of the whole person-physical, emotional, and spiritual. The physician, manifestly, is no expert in every dimension. He or she, however, should be alert to the patient's *needs*[30] in each sphere, do what is within his or her capabilities and work with others in the health care team to come as close as clinical reality permits to meeting the several levels contained in the idea of the good of the patient." (2001A, p. 569). Here, Pellegrino, although only once, introduced the notion of "needs". Needs and perceptions are two different things. In a moral sense, one can argue that the object of *need* can be viewed as an objective thing that a person has to

[30] My emphasis

possess (e.g. I need food in order to survive). In the absence of the object of need, harm will ensue (if I do not eat over a period of time, I will die[31]). Perceptions on the other hand can be viewed as subjective. A person might perceive his good to be X when in reality it is Y. A patient might perceive that it is better for him not to take iron pills because they are causing him stomach cramps when in fact, he is severely anemic and, should he leave his anemia untreated, this will lead to serious physiological loss of function. The assumption here is that health is a 'good' that patients look for. This is why they seek the help of the physician to restore their health (when possible). It might be a view of health as defined by the values of patients, but there are some general parameters of objectivity that constitute health for all (severe anemia will damage the body). Readers of Pellegrino might confuse the word needs above as being the objective need as opposed to the subjective perception of the patient. However, what Pellegrino is referring to is the following: The physical need is the medical good of the patient, the emotional need is the perceptions of the patient, the spiritual need is the spiritual good of the patient. Once this is clarified, the ambiguity disappears. Pellegrino argues that "the medical good of the patient is a four-tiered idea: the medical good, the patient's perception of the good, the good for humans as the kind of thing humans are and the spiritual good" (2010 B). Pellegrino offered a theory where different kinds of goods supersede one another: the medical good is important and "aims at the return of physiological function of mind and body, the relief of pain and suffering, by medication, surgical interventions, psychotherapy, etc." (2001A, p. 569). This good must, however, "be brought into proper relationship with the other levels of the patient's good.Otherwise, it may become harmful" (2001A, p. 569). This good however, is superseded by the patient's perception of his good which has to do with the patient's "personal preferences, choices, and values, and the kind of life he wants to live, the

[31]Hence, one need food, but desires cheese cake.

balance he strikes between the benefit and burdens of the proposed intervention." (2001A, p. 569). Both, the medical good and the patient's perceptions of the good are superseded by the "good for humans as humans". This, he argues, was the good Aristotle wanted to define as the telos of human life (2001A, p. 570). At the level of the good for humans as humans, the familiar principles of medical ethics as proposed by Beauchamp and Childress are taken account of. Pellegrino argues that "in the clinical encounter, the medical good and the personal good must, in their turn, be consistent with, and protect, the good for human beings as humans" (2001A, p. 570). The question that arises here is "what if physicians are not capable of ensuring that?what happens then?" What if, say, the medical good of the patient indicates that abortion is in the best interest of the patient, the patient's perception of her good is that she keeps the baby (personal good)? How can they protect and be consistent with the human good when, to begin with, they contradict each other?Pellegrino's solution to this problem is to resort to the spiritual good, the paramount good which supersedes all. The "spiritual good" is the highest level of good which must be served in the clinical encounter and this is "the good of the patient as a spiritual being, i.e. as one who, in his own way, acknowledges some end to life beyond material well-being" (2001A, p. 570). At this point we are in the realm of the spirit however differently this may be defined by different people. If it violates this good, the medical good "could never be a healing act" (2001A, p 571). This is a strong claim to make for it makes the medical good dependant on the spiritual good. Yet, the three examples that Pellegrino states are extreme cases: 1) Blood transfusions in the case of a Jehovah's witness, 2) abortion of a genetically impaired fetus for a Catholic, 3) discontinuance of life support for an Orthodox Jew. (2001A, p. 571) Yet, we often encounter controversial cases where physicians face conflicting duties and the answer is not straightforward. This is all good for those who believe in the existence of the spirit beyond material existence. But what about patients

(and physicians) who do not? Should we stop at the level of the good for humans? In this case, what solves the problem of the conflict between the medical good and the patient's good? Pellegrino's answer is simple. The physician has to respect the good of the patient, yet she is a human being, not a "patient-own automaton" (2010 B) and she cannot violate her "own moral percept of the good at the pleasure of the patient" (2010 B). Pellegrino's answers: "If the patient asks me to violate my conscience, I say, politely: "No. I cannot do what you want. I am not the best doctor for you." (2010 B) which, to some, might seem to be a morally acceptable alternative. The patient is served and the physician's professional conscience is not violated. However, I argue that this four tiered idea, although interesting, corners Pellegrino in that it reveals an inconsistency in his thinking. It seems that each level of the good can lead to more problems than solutions when it comes to dealing with patients. The medical good is the biological good of the patient and as such, it seems to be the least problematic of them all since it can be decided on a scientific basis. Yet, this good is left subordinate to all the other levels of the good. However, for someone like Pellegrino who argues that beneficence is a primary end of medicine, this good should, perhaps, supersede all other goods (other things considered) because the medical professional is the one trained to know what is medically better for the patient. The patient's perceptions of the good can very well be subjective and might very well conflict with the medical good of the patient. What would or should a conscientious doctor do in that situation? What if the patient's perceptions of his good are false because this patient has an unscientific belief that will damage his life? Should the physician yield to that conception if, after deliberation and education, the patient still sticks to his conception of the good? One major difference between medicine and other professions, like marketing or business, is that in medicine, the patient has minimal sovereignty[32] in asking what he wishes and this

[32] Sovereignty refers to a person's capacity to determine her own affairs while autonomy

sovereignty is limited by the knowledge of the physician and the medical condition of the patient. In other words, if a patient comes in asking for a non indicated surgery with high risk and side effects, the conscientious physician should not grant him this request even if the offer is a lucrative one (for example plastic surgery). Pellegrino says that the patient's conception of the good is superseded by the human good. But who decides what the human good is? Also even if the boundaries of this human good are universal, there remains some goods that are socially constructed and hence, the physician's view of the human good might come into conflict with the views of the patient and/or other physicians. In this case, what should be done? To simply ask the patient to resort to another physician becomes a slippery slope. To solve the problem by resorting to the spiritual good which supersedes all goods is even more problematic for at least two reasons: 1) some patients do not believe in any supernatural entity and to them resorting to a spiritual good is useless; 2) it might very well be the case that the supernatural belief system of the physician and that of the patient might come into conflict, what should be done in this case? To resort to another physician? Does this mean that, ultimately, patients should be seeing physicians who hold the same supernatural beliefs as they do in order to ensure better care (at least as they perceive it)? This is a dangerous conclusion. Pellegrino who contends that the heart of the medical encounter is the physician patient-relationship and gives supremacy to the patient's good argues that the solution that exists whenever there is a conflict between a patient and the physician is to ask the patient to resort to another doctor. This is a form of abandonment of the patient and his good. Perhaps the spiritual good needs to be replaced by the "rational good"; this being the good that any rational physician who has internalized the virtues would choose (after deliberation). This physician will have to use her phronesis and good character to decide what is to be done without morally abandoning the patient

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refers to a patient's right to make decisions about her medical care.

and without encumbering herself with doing deeds that conflict with her moral professionalism.

1.6. Performing Abortion as an Example of Ends External to the Profession of Medicine:

Pellegrino contends that beneficence is the primary principle of medical ethics, that healing should be the exclusive goal of medicine and that acts like abortion and euthanasia are not part of its internal ends. According to him, abortion is an "intrinsically evil act" (2005 A, p. 481) and as such, it cannot serve the moral end of healing. It is conceived of as an end external to medicine, one which allows "complicity with evil" (2005 A, p. 481). Yet, one can argue that performing abortions need not be considered as an end external to medicine per se and that Pellegrino decided to have it as such because he is arguing on the basis of his own (personal religious) beliefs. If abortion is done in order to save the life of a mother, one can argue that this is very much in line with the internal ends of medicine, that it is done with beneficence in mind and cannot be said to be done in complicity with evil. The same can be said of an abortion performed on a fetus that suffers severe fetal malformations that are incompatible with life. Such malformations will only incur harms (physical and psychological) on the fetus (the potential person) and on her family as well as on society[33]. Consider a child with Tay-Sachs, a fatal disease caused by the lack of the enzyme hexosaminidase A. The illness has a genetic origin, and although newborns who suffer from infantile Tay-Sachs look healthy, they have what Arras calls a "decidedly grim" (Arras, 1990, p. 366) life full of suffering and pain -eventually,

[33] Note that the obstetrician has two patients, the mother and the fetus.

the illness leads to total paralysis, blindness and death. Will keeping this potentially miserable child be in line with the ends of medicine which are to help, heal and cure?[34] This issue becomes more problematic now that prenatal tests intended to detect congenital malformations and chromosomal aberrations like sonography, first and second trimester blood test screening, amniocentesis and chorionic villus sampling are available and are being performed to women who can be denied abortions on ground that doctors ought not terminate lives. One might also wonder what is the point of having the means to detect abnormalities in utero when a physician is morally bound not to abort. Almost everyone recalls the horrific birth deformities that ensued from the use of the Thalidomide drug. Hiroshima's 'mushroom cloud' is yet another infamous story that still reverberates in the minds of many. Several people have been touched by radioactive outcomes. Pregnant women gave birth to children with terrible defects and the world is still infuriated. Gallagher relates the story of mother and daughter whose lives have been sternly affected:

> [W]hile she was carrying her daughter in the womb, she was exposed to test fallout that caused nausea, burns, and blisters on her skin and led to the loss of her teeth, hair, fingernails, and toenails. Her daughter was subsequently de-livered prematurely, suffering from cancer, and weighing little more than three pounds. At the age of six months her cancer was treated with crude and unlocalized radiation that deformedher heart, lungs, breasts, and spine. As Diana Lee Woosley aged she suffered from constant vomiting and congestive heart failure and underwent

[34] While there continues to be a lack of universal agreement on what constitutes the minimum requirements for a decent life, and what constitutes a malformation that is incompatible with life, it remains a fact that different people might hold different opinions. It is my contention that before entering into parenthood, parents should ask themselves whether the life that they are begetting will be one that satisfies the fundamentals for decent living, or one with very low quality, surrounded with agony and pain.

> traumatic surgical procedures to correct her spinal deformity. Her face, we learn, is swollen from large doses of prednisone, which she must take to combat the diseases that exploit her weakened immune system-a treatment that has itself caused diabetes. Beyond this suffering of their bodies, however, the women have also suffered psychologically (Taylor, 1997, p. 583).

If the primary end of medicine is beneficence which serves the good of the patient which is the end of the physician-patient relationship, the question that one cannot but ask is the following: How was the good of Diane Lee Woosely's and her mother served when the life that she is leading is pain and agony? Religion and purgation arguments aside, her good has not been served, quite the contrary. If all this could have been avoided by abortion on demand (assuming this was at the earliest stages of pregnancy, and Diane Lee's mother was autonomous and capacitated) this unnatural lottery could have been prevented, the torment, pain, psychological and physical (as well as financial) could have been circumvented.

Thus, one can contend that when it comes to controversial issues like abortion or euthanasia[35], these can fall either within the internal or the external realms of ends, depending on the situation, particularly since, as Pellegrino himself states, the end of (clinical) medicine is caring and curing. Add to it that such actions might serve the good of the patient *as the patient perceives it* which Pellegrino argued supersedes the medical good. Thus, while the physician can be a conscientious objector, one cannot dismiss abortion altogether as being evil or as not being part of the internal ends of medicine as Pellegrino perceives them to be. Put simply, if abortion is done for the purpose of healing and the good of the patient, it serves the internal ends of medicine. So one might argue that

[35]Pellegrino offers a cogent account against euthanasia in "Doctors must not kill" (1988).

abortion might become part of the internal ends of medicine depending on the situation, the medical good, the patient's perception of the good and the good for humans as humans. The Spiritual good is itself grounds for controversy. In certain religions, abortions are permissible at certain times and in certain conditions. For example, Islam allows abortions if the fetus is deformed but provided that abortion takes place prior to ensoulment which is usually said to be at 120 days of pregnancy. After that, abortion is allowed only if the pregnancy causes danger to the life of the mother. In 2008, Al Azhar, which is considered the Muslim Sunni highest seat of learning, declared a Fatwa to the effect that a woman pregnant by rape can abort as soon as she knows that she is pregnant. For the Roman Catholic Church, the fetus is a person at the moment of conception and abortion is a mortal sin. Judaism does not forbid abortion all together (particularly during the first 40 days of pregnancy) but forbids abortion on demand. If it is to happen, there must be serious and stringent reasons (like when the fetus causes a danger to the life of the mother)[36]. In addition, it is also the case that it can be that the medical good of the patient might serve the patient's perception of the good (in case she asks for an abortion) but does not meet the spiritual good as Pellegrino portrays it, which is the higher level of good, nor does it honor the moral absolutes that Pellegrino strongly holds on to. The four levels of the good are bound to conflict because moral life is complex and the cases that physicians face on the floors are complex. Moral absolutes exist but they alone cannot guide the decisions of physicians dealing with such complexities because there are exceptions and grey zones.

1.7. Moral Absolutes:

[36]The moral status of the fetus (concerning questions such as if the fetus is a person then it has rights that belong to persons, including the right to life) is a central issue in the debate concerning the morality of abortion.

In "Some things ought never be done" (2005 A), Pellegrino argues that there exists in the nature of the physician–patient relationship certain moral absolutes which are essential to the realization of the good of the patient (the good of the patient being the end of this relationship). These moral absolutes derive from the principle of doing good and avoiding evil. But how can the definition of medicine be a function of the good of the patient as the patient perceives it and yet, we have a clinical encounter bound by moral absolutes? It is an empirical fact that some patients' perception of their good often tend to disregard (if not disagree with) these subsidiary-absolutes: they seek abortions, they want to have their lives terminated when they are in unbearable pain or when medical treatment is futile, they refuse life-saving measures[37] and at times they want to be lied to[38]. If we are to accept Pellegrino's moral absolutes as overriding (which are elements of an absolutist deontology), the conclusion will be that the physician will not be able to serve the patient's good as he sees it for the patient might see his good as being in opposition to the absolutes Pellegrino presents. Individual perceptions can only accidentally fit with absolute claims and so to with the needs of the patient. However, Pellegrino himself notes that the patient's preferences are not paramount nor absolute since to take it as such would be to "violate

[37] Like the case of a Jehovah's witness patient who simply refuses a life saving blood transfusion. Pellegrino argues that the patient's spiritual good is the highest good which should be accounted. Hence, aborting a genetically impaired fetus or discontinuing life support cannot be considered healing acts since they violate that highest good (2001, p. 571). Yet, it can be argued that many religions nowadays argue for the opposite. Hence the tension between the patient's perception of his good and the moral absolutes that the physician is supposed to follow if she were to be a good physician following the ends of medicine. Still, it is important to note that Pellegrino's conception of the patient's good is not a thoroughly subjective one as it precedes non-maleficence for to him (and Thomasma, 1994) the first principle of medical ethics is to act for the benefit of the patient and if one does that, one, ipso facto, avoids harm.

[38] In a letter sent to him in October 2010 inquiring whether he expects relativists to agree with him, Pellegrino answers "I certainly do not expect the relativists to agree with me. The very use of the term "absolute" excludes that. In the case of abortion, assisted suicide, use of embryonic stem cells, I see no room for compromise. I cannot, morally expect others to comply with my absolutes or impose my concepts by violent means. But, neither can they ask me to violate my conscience" (2010)

the autonomy of the physician[39] and would also amount to asking the physician to lay aside his own moral integrity and to become *value neutral*" which, according to Pellegrino, is a "psychological impossibility" (2001A, p. 572). As previously mentioned, and in a letter dated October 18, 2010 addressed to the author of this dissertation, Pellegrino stated that in case the physician's conception of the good was different from that of the patient at each of the four levels (except in extreme emergency) he would not breach the patient's concept of the good even if that conception is in disagreement at any of the four levels of the good. Yet, this does not mean that he must cooperate and do what the patient wishes. One can also, à la rigueur, argue that the four different kinds of goods offered by Pellegrino can come into conflict: Consider a patient with diabetes. His medical good would be to treat his diabetes and to eat regularly and in small portions, certain kinds of food. His spiritual good however might be that he fasts during certain assigned religious days. Yet, this might negatively impact his health. If the spiritual good supersedes the medical good, then what ought the physician to do in a case where the patient presents to him while fasting complaining of a sudden onset of his disease? Another example would be when a Jehovah's Witness refuses blood transfusions. Here, we have a conflict between the medical good and the human good on the one hand and the perceptions of the patient and the spiritual good on the other. It is a fact that doctors and patients might differ in their perceptions of what makes for human flourishing. Pellegrino's view sheds light on the fact that doctors and patients do differ on what they think of the good (the quadripartite idea) and how they can differ and at what levels. Yet, to him, "the end of medicine is the good. That is what is absolute, but the perceptions, conceptions of that good may be mistaken. The physician is not empowered to override the patient's conception. On the other hand, the patient simply on the basis of his perception of the good (one level only) cannot

[39] The patient will then have to find another physician with sympathetic views.

demand that the physician do what he thinks evil" (2010 A). So, ultimately, and in case of conflict of perceptions of what constitutes the good, no one has a monopoly over the other and the autonomy of each is safeguarded for if the patient were to impose his vision of the good on the physician, this latter will be unhappy and perhaps will not be able to live with herself and her profession any longer (a dissociation between professional and personal conscience), and if the physician were to impose her conception of the good, the patient will be unhappy, not to mention that this trend of paternalism is not viable any longer. Also, if there are things that ought never be done, what is the *good* physician to do in this case? Ought the duties attached to the role of the physician be absolute in nature rather than prima facie? If *good* is tied to *end*, and if a good physician is one who performs her function well by exhibiting well the ends of medicine, then the good physician in this case may have to break the absolutes of medicine and perform medicine situationally[40] in quite an Aristotelian fashion using her phronesis. But did not Aristotle himself speak of things that ought never be done although his ethics is viewed as a situational one? Another question that arises is what happens in cases where the absolutes that Pellegrino talks about come into conflict. Although Pellegrino argues that it is in the nature of the moral absolutes not to conflict[41] (2010 A), one can imagine a situation where the medical good of the patient lies in her aborting a fetus (as mentioned above), or situations when breaking one's promises, depending on the situation, are the morally right thing to do, where protecting the dignity of the patient might lead to the physician letting go of extraordinary measure at keeping the patient alive. Consider the example of euthanasia. Does a patient's right to die

[40] At times, a doctor will have to perform an abortion to save the life of the mother. Yet, in a situation when the mother is a criminal sentenced to death (the court order is final and she will be executed in a few days), it is only normal for the physician to save the life of the baby if it is a situation where only one will live. Here the moral absolutes are violated. It is immoral not to violate them.

[41] In an email to the author of this thesis, Pellegrino commented that "it is in the nature of a moral absolute that it is binding in all situations. (…) Moral absolutes are not like the four principles that can conflict with each other". (Pellegrino, 2010 A)

entail a physician's duty to kill? The question to begin with is about the patient's right to die, a question which, merits a lot of discussion but which falls beyond the scope of this thesis which is not about the ethics of euthanasia. Yet, for the sake of argument, it will be said that to some, like Pellegrino, the physician's duty never to kill is inviolable and paramount while for others, the duty to relieve suffering might outweigh it. Yet for this duty to be inviolable means that it is unconditionally morally binding. This is perhaps a bit too Kantian for the contemporary virtue ethicist that Pellegrino is. Given the complexities of the modern medical conditions, can physicians really have any duties of this kind? I am not contesting that doctors have a duty not to kill, but merely looking at the unconditionality of this duty, particularly for a thinker who stresses the autonomy of the patient, the importance of the patient's view of his good and beneficence as being a primary end of medicine. The duty of the physician here is to provide that patient with whatever will benefit him. But when medical treatment is futile and when the dying patient is increasingly suffering and there is no hope for cure, in what sense can one argue that keeping that patient alive benefits him? Isn't this a blind obedience to rules that is detrimental to the profession and that is in contradiction to the spirit of the *phrominos* who has his eyes on many things at the same time, like the wise steersman in charge of a ship in a stormy weather? Would the benefit (to the patient and his family) not be a quick and painless death *if* , all things considered, this is the wish of the patient? Medicine is based on the patient's right to life. When the patient renounces this right, the physician cannot force it upon him. Pellegrino (1992) argues that euthanasia undermines the trust that exists between physician and patient. To him, when euthanasia is considered, "this trust relationship is seriously distorted. Healing now includes killing. (…) How can patients trust that the doctor will pursue every effective and beneficent measure when she can relieve herself of a difficult challenge by influencing the patient to choose death?" (1992,

pp. 33-34). Some questions arise at this point: what is *included* in that trust? Does the patient trust the physician never to cause his death or to respect his wishes and values about his healthcare choices or to do what is best for him? Would the patient feel that his trust has been betrayed and his wishes were disrespected and ignored when his physician keeps him agonizing against his wishes on a life sustaining machine dying slowly when he can, by a simple act of unplugging, put an end to his misery? Perhaps the physician can be trusted to use her phronesis and decide which acts of euthanasia are morally justified and which ones are not. This is not to say that there is no room for a slippery slope. But this is another issue altogether. By stating that there are certain things that ought "never" be done (and including euthanasia and abortion in this list), Pellegrino is too rigid in his absolutism. The only absolute is the fact that the end of medicine is to heal and cure/care. But at times, to do that, the physician will have to break the moral absolutes Pellegrino strongly holds on to. Is Pellegrino assuming that the physician is someone who already agrees to the moral absolutes she is setting and someone who does not agree to what one might call the 'unconventional way' the patient might view his good?Is this really how things are these days? We have been witnessing (and Pellegrino is aware of that[42]) an era when students are voicing their concern about taking the Hippocratic Oath (or variants of it) precisely because of its absolutism. But he was aware that: "The Hippocratic oath has been in a parlous state, especially in the past three decades, since the rise of contemporary bioethics" (2002 A, p. 99), yet, he continues arguing that "perhaps for many the medical oath is today a shard of a fractured ancient image. But enough of that image remains in the consciousness of the profession to remind us that to forget it entirely would be to make medicine a commercial, industrial or proletarian enterprise" (2002 A, p. 99). The

[42] In 2006, he stated that "[t]he great canon of medical morality, the Hippocratic Oath, is being honored more in the breach than in observance. Each one of its prescriptions has been questioned by some physicians and believed by others" (Pellegrino, 2006, p. 66).

Hippocratic Oath, as well as other oaths, are here to remind medical practitioners of the internal ends of medicine. The question that arises at this point is whether these ends are universal or whether they are a function of particular times and places.

1.8. The Importance of Trust in the Physician-Patient Relationship**:**

Medicine is a human activity and not a purely scientific skill. It is a profession that is actualized during encounters between patients and physicians and its goal is predominantly the good of the patient. The physician, by virtue of her profession, should have no other good in mind. It is this which compels the patient to trust the physician in the hope that she will restore some of the patient's lost autonomy and pride and will do her best to heal him. In other words, the patient trusts that the physician will serve the ends of medicine. As Pellegrino puts it, "[t]rust is most problematic when we are in states of special dependence – in illness, old age, or infancy, or when we are in need of healing" (1993, p. 65). In what follows, I argue that trust is an important ingredient of the physician patient relationship and that trusting the physician entails not only a trust in the system which gave the physician the education and the license but also trusting the character of the physician who will not abuse her power but will do whatever is within her power to heal the patient. This is why it is important to cultivate physicians of fine moral fiber who will do a fine job in serving the ends of medicine as it ought to be.

Trust affects and cements the moral relationship between patient and physician. The personal values of the physician could be external to the ends of medicine. Her values can be governed by self-interest and greed and if this were the case, the physician cannot serve

the internal ends of medicine. One can also add to this the fact that trust can be abused[43] particularly since the patient *qua* patient is placed in a relationship where he is forced to trust the physician with his health. In the medical encounter, trust is valued for what it helps to bring about, it is beyond technical expertise and it is the essence of the medical encounter. Without this element to the encounter, there is no medicine to be practiced[44] and the ends of medicine will not be served as they ought to be since the patient might not reveal the intimacies of his psyche or even illness to the physician in fear that the information might be abused. According to Pellegrino, trust is "ineradicable" (1993, p. 65) and "we need the help of doctors to surmount or cope with our most pressing human needs. We must depend on their fidelity to trust and their desire to protect rather than exploit our vulnerability" (1993, p. 65). After all, the physician-patient relationship which is the heart of medicine is built on trust and hence the physician ought to be trustworthy, someone virtuous enough not to abuse the information she has been given by the patient. Reflecting on trust, Pellegrino contends that trust in the medical profession has drastically deteriorated and that patients view their physicians as being more interested in their money than in them, physicians are viewed as exploiters, rather than guardians, of medical knowledge (1993, 65-78). When physicians overlook the ends of medicine, and concentrate on personal values, self interest, and greed; when they yield to marketplace forces, and look at the patient as client instead of patient; then they lose sight of its moral dimension and, the practice of medicine will be distorted and harm will ensue. The physician-patient relationship is essentially fiduciary which makes the bond of trust vital for the diagnostic and therapeutic processes. As Pellegrino and Thomasma pointed out, "the end of medicine,

[43] The vulnerability of patients can be abused for profit or power. As Pellegrino puts it, "[t]o trust and entrust is to become vulnerable and dependent on the good will and motivations of those we trust" (2003, p. 65).

[44] One of the main critiques against what came to be known as internet medicine is the absence of the clinical encounter and the requisite physician-patient relationship.

its justifying principle, is, in the final analysis, a moral one: the 'good' of a person seeking help. The choice of what ought to be done turns on questions of value, morality and interpersonal dynamics. These questions can be studied scientifically, to be sure, but they cannot be defined by scientific considerations alone" (1981, p.147).The phrase 'good of the patient' means his physical and psychological good. Peabody's exhortation summarizes the key elements of the physician-patient relationship:

> The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of theessential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient (1927, p. 818).

In the physician-patient encounter, trust is essential, has instrumental value (upholds a fractured autonomy, increases cooperation, enhances treatment which is based on correct information, and builds a healthy relationship that is vital for both patient and physician) and is crucial to the success of the entire diagnosis-prognosis-treatment tryad. It is intrinsic in the notion of trust for one to have faith in the good will of the trusted that he will do what is best for the truster. In "Trust and Anti-Trust", Baier defines trust by referring to the expectation of the truster to benefit from the good will of the trusted. She speaks of "intentional trusting" which "require[s] awareness of one's confidence that the trusted will not harm one, although they can harm one" (1986, p. 235). Baier continues to say that often, we need the help of the trusted in "looking after the things we most value, so we have no choice but to allow some others to be in a position to harm them" (1986, p.236). What is it that human beings value most? Health is one of those things, and we entrust it to physicians, believing in their good will not to harm one of our most valued goods. Baier

continues: “Where one depends on another’s good will, one is necessarily vulnerable to the limits of that good will. One leaves others an opportunity to harm one when one trusts, and also shows one’s confidence that they will not take it. Reasonable trust will require good grounds for such confidence in another’s good will, or at least the absence of good grounds for expecting their ill will or indifference” (1986, p.235). This applies especially when the trusted is the physician and the truster is the patient who expects to benefit from the former’s good will as long as the affiliation continues to exist. This ties in quite well with the universal characteristics of the ends of medicine. To my knowledge, patients around the world build their relationship with their physicians on the assumption that they can trust them with their health and privacy. The problem arises when physicians of less than trustworthy character, deceive patients and work for their self-interest instead of that of the patient. Examples abound: physicians who do not refer patients to specialists and continue treating them (and dragging them to their clinic more than necessary) although it is not their specialty, physicians who ask patients to undergo a number of useless tests for personal gain, physicians who are a prey of conflict of interest and do not declare this to their patients, surgeons who do not tell their patients that what they suffer from can be solved by non-invasive procedures, etc. If the physician uses the information that the patient gives her for purposes other than his good; if physicians abuse the power that they have and do not honor the ends of medicine, trust will fall apart, and with it the entire physician-patient relationship cemented by this trust. Patients do not worry, or at least, should not worry, about the motives of physicians when they visit them or disclose information. Their doctors are their advocates and to act any differently would be to betray that trust, to break the relationship and to use the profession of medicine for other than what it is supposed to be[45]. A major safety valve to remaining true to the values of the

[45]Trust is an important part of the physician-patient relationship and a patient who feels

profession and the end of medicine is the possession of a good character, and it is the role of schools of medicine to cultivate such character in the neophyte student of medicine, an issue that will be discussed in subsequent chapters. In medicine, the moral and the technical cannot be divorced or else medicine will become schizophrenic and the practice of medicine will witness its own demise.

Stocker attempted to show that "not to be moved by what one values - what one believes good, nice, right, beautiful, and so on - bespeaks a malady of the spirit." (1976, p.454) He argues that persons will unavoidably have a gap between their values and motives which will lead to a moral schizophrenia. Thus, since modern ethical theories result in this malady, they are gravely defective. Regardless of whether Stocker was right in saying that such moral theories are flawed because they result in a malady of the spirit, it remains a fact that a gap between values and motives will have dramatic effects in a profession like medicine. One might argue that so long as the actions of a physician are in accord with what she should do, then it does not matter what her motives are. I beg to differ. If a person's morality and motives are different, there is no guarantee that this person will continue to behave in accordance with morality (and will do the right thing even when no one is looking). When physicians suffer a disharmony between acts and motives, a malady of the spirit and the intellect ensues. When they have not internalized the virtues and act morally because they are afraid of sanctions, seek promotions, someone is in the room or want rewards, they are schizophrenic (in Stocker's sense), will suffer instances of weaknesses of will and will not be happy. Thus, virtues are essential for the making of the good physician who will not falter nor be lured by the external ends of medicine.

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that he cannot trust his physician will not be able to benefit from the clinical encounter to the full. In such encounters, the ends of medicine will not be met and the physician will fail to do her duty.

Consequently, medical schools need to educate the student of medicine in the virtues[46] and help the student internalize the virtues in such a way so that these virtues become a second nature. When virtues are not internalized, when the character of the physician is not solid enough, the ends of medicine become blurred and physicians falter. That it happened with Asclepius the god of medicine is significant. Pindar's myth portrays the son of Apollo lured by "the love of gain" and "enthralled by a splendid fee of gold displayed upon the palm." (Pindar, p. 191) Examples of physicians who request unnecessary invasive procedures to increase their reimbursement, request redundant tests to supplement their income, admit patients to the hospital unnecessarily, use them as subjects in clinical trials without their consent, or fall victim to conflicts of interest as an upshot of the endowment they accept from the pharmaceutical industry are not anecdotal. In this manner, some physicians abuse the power they have by virtue of being healers.

Another attribute of the physician-patient encounter is an imbalance of power between the truster (patient) and the trusted (physician). On the one hand we have a vulnerable patient with reduced autonomy and on the other an expert who can offer medical care. This vulnerability compels the patient to trust physicians, more so when the sickness is immense and the physician is seen as a shaman in white coat, a deliverer who will save the patient. Physician and philosopher Brody spoke of "power" as being central to the relationship between physician and patient since physicians, owing to their position, have considerable power to alter the course of illness. He proposes three kinds of power that physicians have: Aesculapian, charismatic, and social. The physician by virtue of her education in medicine, possesses Aesculapian power. It is an "impersonal power, it is transferable from any physician to any other of comparable skill and experience" (1993, p.16). Charismatic power cannot be transferred in that it is based on the personal qualities of the physician.

[46] This will be tackled in chapters 2 and 3.

Such qualities include being decisive, courageous, firm, and kind. Social power comes about as a result of the social status of the physician. According to Brody, it is "axiomatic that the use of power must go hand in hand with its potential misuse" (1993, p.20) and he concludes that the main ethical problem that medicine has to face is how to use this power responsibly (1993, p. 36). Brody maintains that "this same power can, with only subtle redirection, be used against the patient's behalf. The problem is to empower physicians for the performance of their essential tasks while protecting the patient from the potential misuse and abuses of power" (1993, p.36). The physician is trusted with "discretionary powers", to use the words of Baier, but the patient assumes (rightly, by virtue of what the word profession means) that the physician will not abuse these powers for the good of anyone or anything other than the patient. This relates again to the ends of medicine, what a physician professes to be, and finally to the importance of bringing up physicians with good character. This, after all, was the predicament of Ivan Ilyich: he went to a physician entrusting him with his health. But he was faced with a character that inspired distrust and service to something other than the ends of medicine, which explains his tragedy as a patient.

In this chapter I have tried to show that medicine is a moral enterprise based on the covenant of trust which forms the heart of the clinical encounter. I have also tried to present some of the basic ideas of Edmund Pellegrino about the ends of medicine being internal to the profession as opposed to an external account of the ends of medicine. I also presented some of his basic ideas relating to the philosophy of medicine and provided some arguments about some of the issues that he talks about in relation to the good of the patient and moral absolutes. I have argued that virtues are vital for the making of a good physician and that these virtues need to be internalized if the ends of medicine (as

portrayed by Pellegrino) are to be met. More will be said about this in the coming chapters. It is my contention that the function of a physician is tied to the ends of medicine. The nature of medicine as a moral endeavour renders this function different from the function of say, a salesman or a craftsman. For each of these vocations, the *telos* is different and, as Aristotle said in the opening of his *Nicomachean Ethics* [47]: "Every art and very inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim"" (1947, p. 307). In medicine, the *telos* is the good of the patient and the physician has to be equipped with certain virtues that "makes a man good and which makes him do his own work well" (1947, p. 338). This was not difficult to achieve and the traditional physician, as portrayed in the painting of Sir Samuel Luke Fildes "The Doctor" back in 1927 seemed to encompass the old image of the virtuous physician. Yet, there has emerged a new paradigm where being virtuous and good seemed to be synonymous to being a simpleton and weak. This moral change had several sources, mostly the same sources that led to the de-professionalization of modern medicine. Thus, what is needed is a new paradigm shift. Education paves the way for the smooth emergence of a new/old paradigm so that it will not be rejected in an era where medicine is back to being seen as the privilege of crude scientists. Therefore, the fundamental question becomes: how can we bring about a physician who demonstrates the character traits that prompt her to act well and in accordance with the ends of medicine?

[47]Hereafter *NE*.

Chapter 2: ARISTOTLE'S VE AND THE PROFESSION OF MEDICINE

> *Must we agree with Socrates that compassion in a medical graduate is a 'gift from the gods'? I think not.*-G. Pence, (1983, p. 190)

Modern moral philosophy in general and medical ethics in particular is reviving its interest in VE and Aristotle is considered its finest advocate whose concern was mainly with "what kind of person one ought to become," whereas the concern of moral theories such as deontology and utilitarianism is primarily with "what is the right action". This is why VE is often referred to as "character ethics", the central notion being that of developing the right character. For Aristotle, ethics had a practical aim: to do good and act well. Hence, his emphasis on *praxis*. A person does the right thing not because he is following a certain rule or out of respect to a certain principle, but, rather, as a result of possessing the right virtues. In chapter I, I argued that medicine is a moral endeavour and that a good character is fundamental to the making of a good physician who should live up to her profession and serve the ends of medicine which are universal and internal to the profession. I also argued that virtues are vital in the making of a good physician. In this chapter I will begin by presenting a brief account of Aristotle's VE and of how the habitual performing of virtuous action will allow a person to eventually acquire the virtues. I will then move on to discuss the role that Aristotle's ethics can play in the moral development of medical students during their years of training in medical schools and thus argue that VE can help in the making of the good physician. Since one might wonder why is it that I have chosen VE and not deontology or utilitarianism I tackle this issue, albeit briefly, and then discuss the inevitable question of whether the virtues can be taught.

Virtues are dispositions in a person's character that prompt him to act in a particular way. Applied to medicine, we can say that what motivates the action of a physician is her character. Hence, virtues have an important role to play in the ethical conduct of a person. So what is virtue and how is it acquired?

A brief account of Aristotle's VE as presented in his *NE* is indispensable in order to answer these questions. Aristotle opens his NE stating that everything we do aims towards some good and that every action has a goal for the sake of which we act. Thus, "the good has rightly been declared to be that at which all things aim" (1947, p. 308). This, good, he argues, is the chief good which is "always desirable in itself and never for the sake of something else" (1947, p. 317). This chief good we are later told is *eudaimonia*, usually translated as happiness or human flourishing. Furthermore, Aristotle maintained that what human beings should do or how they should behave is contained in their very nature, just like the acorn seed has in it the potential of developing into an oak tree. Thus, when human beings develop as they ought to develop, they flourish and become happy: "Pleasure completes this activity (…) as an end which supervenes as the bloom of youth does on those in the flower of their age" (1947, p. 526). The opposite is equally true. A heart that pumps blood well is, in that sense, a happy heart, one that is ailing and does not perform its function well is not. The notion of a 'function' is central to Aristotle's philosophy of human flourishing for "the good and the well' is thought to reside in the function" (1947, p. 318).

According to Aristotle, everything has a function. The function of a knife is to cut and the function of a heart is to pump blood. However, since the human soul is distinctive in its capacity to reason (the appetitive and vegetative parts we share with other organisms), the function of human beings is to live an active life in accordance with reason. Furthermore, Aristotle says that "the virtue of man also will be the state of character which makes a man

good and which makes him do his own work well"[48] (1947, p. 338). Thus, the notion of virtue is tied to the notion of function and the highest good (*eudaimonia*), which is chosen for its own sake: "Virtue, then, is a state of character concerned with choice, lying in a mean, i.e. the mean relative to us, this being determined by a rational principle, and by that principle by which the man of practical wisdom would determine it" (1947, p. 340). A person possessing virtues will eventually act in accordance with them and will even reach a state of inner happiness since happiness is an activity of the soul in accordance with virtue. The virtues that the person develops will, with time, become "second nature" and develop into character traits akin to congenital dispositions that are reliable and stable. Equipped with these traits, a person can be relied upon to act dependably over time. In book one of his NE, Aristotle argues that the chief good is a life which is peculiarly human. The good proper to man, a rational activity in accordance with virtue, can be understood as intellectual virtue (e.g. wisdom) or moral virtue (e.g. honesty). What does a virtuous activity consist of and how are virtues acquired?

2.1. Virtuous Activity and the Acquisition of Virtues**:**

Consider the following scenario: you are walking down the street and you see a beggar whom you know to be needy and sick. You have always walked by him and you have never been charitable to him although you have always had more than enough money on you. On that particular Tuesday morning, as you were walking with people with whom you are trying to do business, you give him money making sure that your partners see your act of 'benevolence' hoping they think of you as a charitable and good person as this might

[48] Unlike his teacher Plato who believed in one Good in the world of Forms, Aristotle believed that everything has its own good (animals, plants, humans). This good is defined by examining the nature of the entity in question. The nature of that entity is, in turn, understood by looking at its function.

positively affect the course of your business with them. Aristotle would argue that this is not a virtuous activity although generosity and benevolence are virtues precisely because of the *reason* for which charity was given. Thus, a person's action is directly related to the virtues of that person and to his character. Had you given money to the needy beggar because you are a charitable benevolent person by character, this would have been different. Thus, unlike the outcome of the arts, the important thing is not merely the act that was done but *how* it was done. The worth of a virtuous activity is in attaining a virtuous character. Aristotle put forward three conditions that must be met for an act to be considered virtuous: "The agent also must be in a certain condition when he does them; in the first place he must have knowledge, secondly he must choose the acts, and choose them for their own sakes, and thirdly his action must proceed from a firm and unchangeable character" (1947, p. 336). Virtuous activity is such that it implies the acknowledgment of, and acquiescence to, an ideal of human excellence which leads one to that which is noble (*kalon*). Thus, in the example above, the benevolent person should choose benevolence because benevolence is noble and because it contributes to human flourishing (although not in the sense of being a means to an end, since a flourishing life consists in virtuous activity). This brings us back to the notion of *praxis*, a peculiarly human activity which pushes one towards that which is noble and worthwhile. Now since happiness consists in virtuous activity, the central question becomes: how does one become virtuous?

Aristotle is renowned for his view that virtues and vices arise through habituation: "moral virtue comes about as a result of habit" (1947, p. 331). According to him, we acquire the virtues (and the vices) just like we acquire the arts and the crafts, through a process of learning marked by repetition and habituation: "[T]he virtues we get by first exercising them, as also happens in the case of the arts as well. For the things we have to learn before we can do them, we learn by doing them, e.g. men become builders by building and lyre-

players by playing the lyre; so too we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts." (1947, p. 331). Thus, a physician who deals inhumanly with patients will acquire the habit of inhumane dealing and becomes an inhumane physician. To become a humane physician, she must break the old habits she had and acquire new habits of humaneness. An important point in his philosophy of education has to do with the fact that human beings cannot learn something that is contrary to their nature: "for nothing that exists by nature can form a habit contrary to its nature. For instance the stone which by nature moves downwards cannot be habituated to move upwards, not even if one tries to train it by throwing it up ten thousand times; nor can fire be habituated to move downwards, nor can anything else that by nature behaves in one way be trained to behave in another. Neither by nature, then, nor contrary to nature do the virtues arise in us; rather we are adapted by nature to receive them, and are made perfect by habit." (1947, p. 331). He also contends that "it makes no small difference, then, whether we form habits of one kind or of another from our very youth; it makes a very great difference, or rather *all*[49] the difference"[50] (1947, p. 332). Ultimately, habits become second nature. They can be unlearned but it is not a quick and easy process. To learn good habits and unlearn bad ones, proper training is needed. However, this cannot be done alone as one needs the guidance of a teacher, a role model, a mentor so to speak. Such teachers should be virtuous persons themselves. The virtuous teacher possesses the necessary wisdom to guide others and is a role model to emulate[51]. Ultimately the learner will learn

[49] Italics in original.
[50] Thus, the double challenge in medical school to help medical students unlearn bad habits and learn good ones. Is there enough time to do this? How can this be assessed? These issues will be considered in chapter 4.
[51] One question that arises at this point is the following: to learn good habits and unlearn bad ones one should (among other things) have a good teacher, a role model. What about the first teacher/role model (let us call this the problem of the first generation), how did he acquire the virtues in the absence of a first wise teacher? Did he just emerge? These are questions worth pondering.

to do the virtuous activity for its own sake; he will be keen on engaging in it because it is noble.

The heart of Aristotle's account of moral virtues lies in his doctrine of the mean. Thus, virtue is a mean lying between excess and deficiency: courage is a mean between cowardice and rashness; modesty is a mean between shamelessness and bashfulness. The mean, says Aristotle, cannot be measured mathematically and indeed, there is no miraculous formula or a magical 'moral calculator' in order to help make the right decisions. This is why, "it is no easy task to be good. For in everything it is no easy task to find the middle, e.g. to find the middle of a circle is not for every one but for him who knows; (…) but to do this to the right person, to the right extent, at the right time, with the right motive, and in the right way, that is not for every one, nor is it easy; wherefore goodness is both rare and laudable and noble." (1947, p. 346). All moral virtues are about passions and actions and they allow "excess, defect and the intermediate" (1947, p. 339) and virtue is a type of mean, since "it aims at what is intermediate" (1947, p. 340), the intermediate being that which is suitable to the particular situation. For example, speaking of certain passions and emotions, Aristotle states: "to feel them at the right time, with reference to the right objects, towards the right people, with the right motive, and in the right way, is what is both intermediate and best, and this is characteristic of virtue" (1947, p. 340). Ultimately, he summarizes his view of the virtues by stating that "virtue, then, is a state of character concerned with choice, lying in a mean, i.e. the mean relative to us, this being determined by a rational principle, and by that principle by which the man of practical wisdom would determine it" (1947,p. 340). Practical wisdom (*phronesis*) is the new and very important crowning characteristic (the art of practical judgment) that Aristotle introduces here. *Phronesis*, the capacity to think about practical matters, allows

for deliberation and judgment in difficult moral situations. Practical wisdom, Aristotle tells us “is the quality of mind concerned with things just and noble and good for man” (1947, p. 438). In it, intellectual and moral virtues are united and the *phrominos* can see what is the right thing to be done for “moral virtue makes us aim at the right mark, and practical wisdom makes us take the right means” (1947, p. 439). It involves a blend of understanding and experience, and consists of the capability to deal appropriately with specific situations. Thus, a person of practical wisdom draws on previous experience and is continuously enhancing his understanding in light of specific situations he is faced with.

2.2. Aristotelian Ethics and the Medical School**:**

Osler was one of the physicians who insisted on the importance of the character of the neophyte physician and stressed the importance of education of the heart in addition to the mind (1906). Along the same lines, Brody cautions against treating patients as chunks of meat transported from one part of the hospital to another (1992). Patients are human beings with a past, a present and a future. They carry the weight of their illness and their damaged autonomy and injured dignity with them. These are even more compromised by having to succumb to a relationship of power imbalance which makes it essential that the physician behaves in a certain way. This latter has to be a certain kind of person that a business man, a hairdresser or shoemaker need not be. What mechanism is there that guarantees the making of such a physician? To begin with, education plays a major role in the making of physicians. One can argue that the purpose of medical education is not only to produce a physician, but a *certain kind* of physician. The medical curriculum is said to be designed to achieve these goals and medical faculties across the world have mission statements with a section about the moral education of students. For example, Yale University School of Medicine states that students of medicine should be “committed to serving others and

devoted to the care of their patients. They must bring intention and action, as well as empathy and compassion, to the doctor-patient relationship. They must demonstrate honesty and integrity in all of their professional interactions" (Yale University School). The Johns Hopkins University mission statement states that graduates will "[d]isplay the personal attributes of compassion, honesty and integrity in relationship with patients, families, and the medical community" (The Johns Hopkins) and the American University of Beirut Faculty of Medicine speaks of "a strong commitment of the faculty to educate young men and women to become excellent physicians with humane and high ethical standards, as well as technical expertise" (Faculty of Medicine, p. 372). The Association of American Colleges Learning Objectives for medical student education states that physicians must be altruistic, honest, compassionate, and respectful (AAMC). Mission statements are public promises and open declarations. Thus, schools are, and ought to be, held responsible for them. Hence, the question arises as to how can medical schools live up to these mission statements and educate students of medicine to grow into upright doctors? Here, it is my contention that Aristotle's VE becomes relevant for when we speak of "compassion", "empathy", "honesty" "humane physicians", "ethical standards", and other similar traits, we are referring to habits and attitudes, not to matters of knowledge. Desired student outcomes (in our case, that of the medical student) cannot be sought outside the realm of character. First, what is so particular about the medical student (the doctor-to-be) that makes it vital to worry about his character (which is not the case, perhaps, of the novice shoemaker)?

Medical students are on the way to becoming physicians and to join a profession that has a special and different significance to it. This is precisely why the student of medicine is made to take an Oath upon graduation and it is this Oath, not the medical degree, that imposes on him a commitment to a certain manner of life that the shoemaker or the

hairdresser is not obliged to have[52]. The oath is an assertion that strengthens the physician's determination to behave with integrity in times of conflict and weakness. As stated by Pellegrino, "without the Oath the doctor is a skilled technician or laborer whose knowledge fits him for an occupation but not a profession" (2002 B, p. 379). This Oath is in so many ways a commitment to a way of life. According to Jonsen, Galen spoke of the medical student as one whose life is shaped by temperance and justice and lives by other virtues as well (2000, p. 10). Galen's ethics stresses mainly the character of the physician, emphasizing virtues rather than duties and rules (2000, p.11). People who take an oath are oriented towards a certain way of life, and, as Sulmasy says, "swear to be certain kinds of persons" (2006, p. 96). Therefore, as Sulmasy continues, "the ethics of an oath ought to be the ethics of virtue" (2006, p. 96) and this ethics "points to a transcendental ideal (toward moral perfection) and demands a sincere effort to strive towards that ideal." (2006, p. 97) Thus, the good physician is the one who, in addition to being skilled, also possesses certain character traits. There is a need for character traits precisely because of the nature of the medical profession which is closely tied to the ends of medicine as described in chapter one. How does one ensure that students of medicine will develop into the physicians expressed in the different mission statements of medical schools? Put differently, how does one ensure that these potential physicians will possess the character necessary for them to be good physicians?

2.3. VE and the Good Physician**:**

VE has witnessed its rebirth in modern day thought particularly with Elizabeth Anscombe's article 'Modern Moral Philosophy' (1985), and Alasdair MacIntyre's *After*

[52] There are other professions who do take an oath like lawyers, nurses and some educators. In that sense, they do have some moral *oughts* they have to abide by.

Virtue(2007). One of the major strengths[53] of virtue theory is its being a theory that concentrates on developing the character of the agent instead of relying on rules and hence, the fact that it does not rely on notions of moral obligation[54] per se. Relying on moral obligations does not give the guarantee of consistency in good deeds that, arguably, VE does as a result of developing a virtuous character. One question that arises at this point is why Aristotle and not Slote or someone else for that matter? My answer to this question is rather simple but straightforward: Slote's moral sentimentalism (his agent-based philosophy) offers a theory about morality according to which empathy (which he labels the "cement of morality" (2010, p. 27) can be conveyed to children through induction and modeling (drawing on the work of psychologist Martin Hoffman). Slote does not put forward a full theory of moral education that can guide us into graduating virtuous physicians, rather, presumes a sentimentalist standpoint of morality which "rests on the idea that being moral amounts to being (fully) empathically caring *vis-à-vis* others" (2013, p. 31). He assumes that empathy exists but needs to be nurtured. However, we are not told how, if at all, it can really be nurtured in adults (which is crucial for our project). He argues that empathy arises in a normal way against the background of self-interest and we are more empathic with or towards those who are close to us, whom we live with, etc., than we are to strangers or people we do not know personally and "this difference can (therefore) mean that we prefer to help the former, even if we are in a position to do somewhat more good for the latter" (2010, p. 131). This can justify Dr. Kate being more empathetic towards her sick cousin in room 301 than to the victim of an MVA in room 805 whom she never met (and the actions that might ensue). To the students of Dr. Kate, this might not be a good educational opportunity either. Slote argues that empathy or caring is

[53] Why VE and not deontology or utilitarianism for example is an issue I will come to shortly.
[54] Such notions, argues Anscombe, are based on theological background assumptions that do not hold any longer.

"the basis of moral right or wrong" (2013, p. 22). It consists in mirroring the feeling of another person, in an emotional identification with the predicaments and suffering of the other, neurologically activated through the mirror neuron mechanism which forms the basis for altruistic motivation and action. Yet medical practice is full of instances where physicians do not have the feeling empathy 'aroused in themselves' because they are caring for unconscious or PVS patients. In addition, there are times when morality requires the physician to weaken her empathic connection and rely on reason and practical wisdom in order to be able to care for her patient. So while Slote's moral sentimentalism can be used in teaching students of medicine to be more empathetic towards their patients, and while his account that moral action has its origin in family and peers is plausible and defensible; it does not help us in graduating the virtuous physician who might matriculate into medical school with character flaws. Other virtue ethicists, such as Foot, MacIntyre and Hursthouse equally have their own contemporary philosophy none of which gives a framework that guides us in our project aiming at the moral education of the future physician. Foot expounded a naturalistic theory of ethics: goodness is to be seen as the natural flourishing of humans and virtues must engage the will, depend on human nature and are *corrective* in that they exist to fight a temptation or a defect in motivation. She compares humans to planks of wood which naturally change form and require constant efforts to make it straight. Virtues do the same for the human character. However, she does not tell us *how* this "strengthening" takes place. Consider Drs. Helen and Kate who work at the same teaching hospital. Each has a possibility to charge patients without examining them by simply asking students to have patients sign the consultation form. The idea never occurs to Dr. Helen and, one can argue, she is naturally virtuous. However, Dr. Kate is often lured by the temptation of having some extra money (she has a mortgage to pay) but overcomes this temptation. The virtue of Dr. Kate lies in her overcoming the temptation.

But, in Aristotle's framework, she is a *continent* person and lacks internal harmony. If, as Foot maintains, virtue is a "corrective" disposition, then Dr. Kate is not fully disposed to be honest and thus cannot be virtuous in Aristotle's terms since the virtuous person wants to do what is right and takes pleasure in it. In *Virtues and Vices* she raises the question *whether the benefit of the virtues go to the person with the virtue or to the people who are affected by that person* and argues that with some virtues (like courage, temperance and wisdom) the answer is apparent as they benefit the person who has these dispositions and others as well. With justice and charity, the answer is not as clear. It seems as if the charitable person benefits the other more than himself and "may seem to be deleterious to their possessor" (Foot in Sommers 2012, p. 320). It might even be that the charitable person loses in the performance of the virtue. For neophyte students to sense that performing such virtues is deleterious (with their immaturity, inexperience, human nature being what it is, and with the current conditions of life) is damaging to the nurturing of the virtues. Foot also argues that a person's moral dispositions are judged by his intentions which, in the educational project we are aiming at, sound a little bit elusive. Would we really want students of medicine to judge (and learn from) the behavior of a physician based on her "intentions" and how sound/right is that?

MacIntyre on the other hand argues that virtues are acquired qualities that allow us to achieve goods internal to practices and they are developed through shared practices. We learn by doing and by pondering our behavior jointly with others through a 'practice'[55]Reflecting on the 'practice' is an essential part of moral development. A person,

[55]A practice is "any coherent and complex form of socially established co-operative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (1984, p. 187) Examples are chess, painting, music, farming and medicine (among others).

he tell us is a "story-telling animal" (1984, p. 216) and it is important to know what stories one finds oneself being part of. This "narrative quest" (1984, p. 218) allows an education of character and self-knowledge. After looking at a varied number of historical accounts of virtue, he concludes that the prevailing differences are the result of dissimilar practices which engender different conceptions of virtues: Virtues (the most important ones now he says are justice, honesty and courage) require explanation of social and moral features in order to be understood and are dependent on the context of the society in which they are exercised (for example, Homeric virtues are understood by looking at their social roles in Greek society). How stable are such virtues and to what extent can we count on them to build the character of a physician who will do the right thing even when no one is looking? Consider a physician who has been practicing in the KSA for 20 years. MacIntyre's virtue theory entails that she will have to change her virtues when she starts practicing in the US. This has unpleasant repercussions on the character and stable dispositions that we are trying to build and MacIntyre does not deal with such problems. His theory on virtue rests on the excellence involved in any established practice (medicine being one) and the importance of living a coherent narrative given one's individual culture and obligations. Virtues help to "sustain the households and communities" together and will also increase "self-knowledge (…) and knowledge of the good" (1984, p. 219). This would imply that a physician aiding a women abort a fetus with birth defects is virtuous since she is keeping

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So in a way, a practice is intentional, and goods internal to that activity are basically realized. He then continues: "A virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods" (p.191). With medicine as a 'practice', its good is completed whenever a number of patients are cared for on a daily basis (when the ends of medicine are met). Yet, the success of this practice does not depend on it alone as medicine is not an edifice that stands on its own, at least not any longer: universities, research institutes, drug companies, insurance companies, governments and other stakeholders have a role to play.

the community together because the husband of the women threatened to divorce her if she keeps it. Again, MacIntyre does not deal with such concerns. According to him, we live "after virtue" because of modern day individualism as the self has no tradition to learn the virtues from.

In his "How to seem virtuous without actually being so" (1999), MacIntyre contends that society comprises "a number of rival and incompatible accounts of the virtues (…) there can be no rationally defensible shared programme for moral education for our society as such, but only a number of rival and conflicting programmes, each from the standpoint of one specific contending view" (1999, p. 118). This is so precisely because a conception of the human *telos* is lacking in a pluralistic society marked by 'counterfeit rhetoric'. Education into virtues "has to begin by discovering some way of transforming the motivations of those who are to be so educated" (p. 123) and educators face the problem of not being able to make students value the virtues as such and to create in them the motivation to be genuinely virtuous. Students will consider particular situations but will fail to understand what is it about the actions that make them "genuine examples of some particular virtue" (p. 123). He concludes that "what the morality of the virtues articulated in and defended by the moral rhetoric of our political culture provides is, it turns out, not an education in the virtues, but rather, an education in how to seem virtuous, without actually being so" (1999, p. 131) which is not what we want for our future physicians. Waiting for a new 'St. Benedict' cannot be the solution. So while MacIntyre's theory has many merits, it does not offer a framework that will allow us to construe a plan to graduate the physician who will do the right thing even if no one is looking. What about Hursthouse?

Like Aristotle, Hursthouse maintains that when persons act virtuously they act in the characteristics of their nature as human beings and this will lead to *eudaimonia*. According to her, it is a strength of VE that it does not resolve all moral dilemmas for this is a correct portrayal of moral life: "Here we come to an interesting defense of the v-rules[56] often criticized as being too difficult to apply for the agent who lacks moral wisdom. The defence relies on an (insufficiently acknowledged) insight of Aristotle 's – namely that moral knowledge, unlike mathematical knowledge, cannot be acquired merely by attending lectures and is not characteristically to be found in people too young to have much experience of life." (1996, p. 650). While she refers to the acquisition of moral knowledge, Hursthouse does not explicitly dedicate anything to moral education and we are not told what to do with the young who do not have much experience with life (like the neophyte student of medicine having a set of v-rules whose guidance seem to conflict). Still, without using the actual term, she alluded to 'role models' in her "Virtue Theory and Abortion"(2011) warning against taking *do what the virtuous agent would do in the circumstances* literally: "virtue theory is not limited to considering 'Would Socrates have had an abortion if he were a raped, pregnant fifteen-year-old?'" (2011, p. 244). Thus, although Hursthouse does not counter Aristotle's moral education, notions of habituation and role models, she does not offer her own full theory (at least in print).

So while Slote, Foot, MacIntyre and Hursthouse have clearly a lot to offer, none of them offers a theory that allows us to graduate the physician who will do the right thing even when no one is looking. Aristotle's theory with its emphasis on rationality, character development through habituation, the role of phronesis in deliberation, *akrasia* and its effects, the importance of virtues in leading a happy and harmonious life, seem to me to be

[56]V-rules are (virtue rules) "Do what is honest/charitable; do not do what is dishonest/uncharitable" (Hursthouse, 1999)

a good model for what I want to argue .So all in all, Aristotle offers a good framework. I do not rely on all of Aristotle's ethics, indeed, and most importantly, this dissertation is not on VE per se, rather it is an attempt to deal with the problem of the corrupt medical profession and how this can be remedied by educating the good medical student who will be brought up to do the right thing even when no one is looking. Hence, in what follows I will try to show how Aristotle's VE has in it the seeds of a good and sustainable structure for the making of the good physician who will do the right thing even when no one is looking. This may be only one way of solving this problem.

Aristotle's VE is quite relevant to the medical profession. It ties the moral virtues with the kind of person the physician ought to be with the excellence of her work. As such, it has practical implications for the making of the "good physician". Consequently, one can argue that admission criteria have bearing on the sort of student who enters medical school to begin with since his moral fiber has bearing on the kind of future physician he will end up being[57]. In other words, since character is partly formed by family, friends, circle of close associates, school, neighborhood, church, etc., then not anyone should be allowed to enter medical school and a sort of sifting should take place upon admission. Medical College Admission Test (MCAT) scores, however important, should not constitute the sole parameter to judge nor should medical interviews that cannot assess the character of the applicant. It is implied by Aristotle's approach that students who enter medical school with no knowledge can be taught knowledge but if they enter medical school with an appalling character(for example a psychopath like the notorious case of Dr. Swango), they cannot be taught good character. The likelihood of success in changing flaws of character during education would depend on several factors, the most important being: 1) the extent to

[57] More will be said about the importance of admission criteria and their relationship to the character of the applicant to medical school in chapter 4.

which the individual's character has been 'fixed': Several studies have shown that by the time students enter college years, their character has not been totally fixed and that some change takes place (Branch 2000; Feudtner & Christakis, 1994).These students must be predisposed to being able to identify virtuous behavior, are motivated to become virtuous and can conquer their emotions and control their desires and actions by a rational principle. This does not mean that they will have to crush their emotions for indeed the latter are important and must be experienced in a proper way for character formation involves developing certain interests, refining some desires, and accepting some emotions. For Aristotle, virtuous people take pleasure in what they do (1947, p. 526).2) the competence, determination and resourcefulness of the educator: The educator and role model has to show evidence of wide knowledge and expertise as well as phronesis. She should be armed with moral courage and have a commitment to stand up for/act upon her ethical beliefs. Thus, the gap between what is said and what is done is bridged and ethical values at risk are protected. She should be a person with a determination to make a difference. 3) the extent to which education takes place in a supporting and sustaining environment (including appropriate role models and credible sanctions): this educator or role model will not be able to thrive or have the influence needed on the students of medicine unless she is working within an supportive environment, otherwise, forces in the opposing direction will hurdle her efforts in making a difference. More will be said about these issues in chapter 4. Here two important issues arise: (1) admission criteria should give credence to candidates of high moral character[58] and (2) once in medical school, students should not be guaranteed that they will graduate *if and only if* they meet the curriculum requirement. In other words, if they falter in morals they should be asked to leave. More will be said about these issues in chapter 4. To my knowledge, no medical school to date attempts to do this.

[58] Some schools started using the REST test, other the DIT test. But even these tests fail to truly assess the ethical sensitivity of the student.

Hence, starting with what we have in medical schools already, how can we work on shaping the character of the students of medicine who are already there? Going back to the ends of medicine (explained in chapter one) we realize that the student of medicine has to be equipped with a number of virtues that will ensure he will not fall prey to personal interest, and to the "sins of modern medicine". These sins, according to Pellegrino are many, including, but not limited to "overspecialization, technicism; overprofessionalization; insensitivity to personal and sociocultural values; too narrow a construal of the doctor's role; too much "curing" rather than "caring"; not enough emphasis on prevention, patient participation, and patient education; too much science; not enough liberal arts; not enough behavioral science. Too much economic incentive; a "trade school" mentality; insensitivity to the poor and socially disadvantaged; overmedicalization of everyday life; inhumane treatment of medical students; overworked by house staff; deficiencies in verbal and nonverbal communication" (1979, pp. 9-10). Medicine is becoming morally bankrupt; physicians are turning into entrepreneurs because they feel that they have to fulfill the demands of the "market". It is also argued that the pluralism that characterizes modern society makes defending the acquisition of a unique set of virtues difficult. Hence, there is a need for what I called "core traits" or "core virtues". We are not looking for a *unique* set of virtues. Rather, we are attempting to find "*core* virtues" that play the role of universals within medicine. Yet, one can correctly wonder if these *core virtues* were to be internalized, what guarantee do we have that virtuous physicians will not be lured by external forces and that the virtues will not be lost? Would these be virtues in the first place or simply *accidental traits*? As was mentioned previously, the Aesculpian myth by the poet Pindar depicts the god of medicine driven away from the Aristotelian virtue of moderation and fallen a prey to vice. Thus, we read about the tragedy of Aesculpius:

> Even the lore of leechcraft is enthralled by the love of gain; even he was seduced, by a splendid fee of gold displayed upon the palm, to bring back from death one who was already its lawful prey. Therefore the son of Cronus with his hands hurled his shaft through both of them, and swiftly reft the breath from out their breasts, for they were stricken with sudden doom by the gleaming thunderbolt. (Pindar 1924, p.191)

To this one might add that if the end of the physician-patient relationship as presented in the ends of medicine is ultimately healing and helping and relieving of suffering, then, core virtues play an important role in the fulfillment of these ends. They offer a guarantee that the student of medicine, who will grow up to be a physician will not falter even when no one is looking. As they are internalized and become second nature, the physician will not be able to act except based on these virtues. It is this that will make her fulfill her function as a physician and lead a harmonious happy life with her profession. The good virtuous physician will be one who demonstrates the core character traits which most successfully realize the ends of medicine. Some of these virtues, as presented by Pellegrino and Thomasma are fidelity to trust, compassion, phronesis, justice, fortitude, temperance, integrity and self-effacement[59] (1993).

So how do students of medicine learn these excellences or core virtues? It is here that Aristotle's theory of virtue as habituation (along with the crowning characteristic of phronesis) comes in. Medical students need to be habituated to doing the right thing and habit will become a second nature. With time, they will learn to develop the capacity to deliberate about complex situations and reach the appropriate conclusions. In *phronesis*, the intellectual and the moral virtues are united and the moral agent is capable of

[59] Francis Walker (2005) suggests the cultivation of the additional virtues of tact, good humor, self-awareness, and simplicity, reverence and courage.

prioritizing the virtues and of making the right decision when faced with situations that offer complex moral conundrums. He will be able to make the right clinical decision which earlier on seemed too difficult to make. The virtuous physicians will be safeguarded from the possible metamorphosis that might mean that another physician falls prey to the sins of medicine. In that sense, core virtues function like safety valves against the sins of modern medicine. Notwithstanding, this presupposes that medical students who are already in medical school have some predisposition to become good physicians. According to Aristotle, we do not acquire a virtue that is contrary to nature. For Aristotle, humans do not have an innate character imbedded in their nature that makes them the kind of persons they are and hence are not amenable to change. Rather, at birth, persons possess a potentiality out of which a set of qualities (character) develops. The mere fact that character changes proves this. As Aristotle says, a "stone which by nature moves downwards cannot be habituated to move upwards" (1947, p. 331). The stone totally lacks the potential of learning how to fly. This task, which is not only challenging but impossible, is doomed to failure. No teacher or trainer can be so effective.If character were innate, it would not be open to change, just like the stone, but it is not. A 'normal' person however, is educable: he could be brought up to become a 'virtuous adult'. But not all 'normal' persons and students of medicine will grow up to become virtuous individuals and virtuous physicians. As in the case of the acorn: for the acorn to become an oak tree, a proper environment that provides the necessary conditions is required in order for the potential to be realized and for the acorn to become an oak tree. Yet, one cannot but wonder about the character of the student of medicine who enters medical school and is resistant to change. The fact remains that there are persons who should not be in medical school at all, who are characterologically flawed and who, in a sense can never be corrected, an issue that will be dealt with in Chapter 4. There are also unsuccessful experiments of students who were

initially admitted to medical school as “work in progress” but who nonetheless did not develop the virtues one hoped they would. Such students should not be allowed to graduate and deal with the lives and health of vulnerable patients. These are not a majority, but they should not be ignored and action should be taken. Would one tolerate a medical student who ridicules the narratives of patients, who thinks character is irrelevant and sincerely believes that ethics has no room in medicine which he views as solely a scientific endeavour devoid of moral scruples? A medical student who enters medical school whose character is miserably shaped in the wrong direction, with no desire to change and who does not see in medicine anything but a gate to prestige and power might be a failing experiment and, perhaps like Aristotle’s Alexander, a tragic hero. Aristotle's greatest pupil and his utmost failure, Alexander was a vigorous personality, unified what had previously been scattered city-states, that also lead to the end of democracy. He had several flaws to his personality, yet, perhaps Alexander’s main tragic flaw was suffering from what Aristotle calls ‘weakness of will’ (*akrasia*). Aristotle defines an *akratic* agent as one who “knowing that what he does is bad, does it as a result of passions” (1947, p. 443). He thought of *akrasia* as lack of self control and the persons who exhibit a lack of self control (*akrates*) will not possess practical wisdom. An *akratic* student (who knows what he ought to do but fails to do it because of his unruly feelings) will be torn by conflict as his rational and emotional faculties will not speak the same language. This is precisely why, says Aristotle, such persons are unhappy while the virtuous persons are happy and at peace with themselves. One question that might arise in connection to *akrasia* is the following: is it possible for a physician knowingly not to do what she thinks is best for the patient? One might answer this by saying that, in principle, this is not possible. Yet, practically, a physician with a flawed character can be lured to do that which she knows is not best for this particular patient. Take the example of patient (A) who suffers from an organ failure

and is in need of an immediate organ transplant. Security at the hospital is tight and the physician of that particular patient happens to have another patient (B) who is terminally ill and will die in a few days anyway. Patient (B) is a perfect match for patient (A). The physician is told by the family of patient (A) that should he secure the organ and should the transplant be successful he will be awarded a generous amount of money. Lured by the prospect of economic gain, and convincing herself that patient (B) will die anyway in a few days, she hastens the death of patient (B) removes the organ and gives it to patient (A). This will not happen had the doctor internalized the core virtues. A virtuous physician will not find it difficult to do the right thing, indeed it will be against her nature not to do so. She will not simply have virtues; she will *become* her virtues. For Aristotle, the virtues make the person do his work well and make him a good person: "[t]herefore it is true in every case, the virtue of man also will be the state of character which makes a man good and which makes him do his own work well" (1947, p. 338). As such, the virtuous physician will not be metamorphosed under any circumstances but will stand firm even when no one is looking, even if security is not tight and if she can get away with it. Notwithstanding, this is not to say that VE alone will suffice in guiding the conduct of the future physician. Rules and duties will also play an important role in that they offer some guidance to the neophyte student who is still building his character. In addition, even when fully formed in terms of character, the physician cannot act regardless of the rules and duties set by the organization, society and profession in which she is practicing. These rules and duties are moral as well as institutional/professional in nature (being part of an institution/profession entails agreeing to work within certain moral parameters set by the institution/profession. Even if this agreement doesn't reach the status of an enforceable contract, there is an obligation to do the things that are agreed upon, especially if others like patients, other members of the healthcare team, etc., are relying on them to do so. The

assumption being that these rules and duties are such that they do not violate the general moral decorum. She will have to exercise prudence but still regard and respect the rules and duties that are present and endorsed for a reason. Here, one can recall the moral absolutes presented by Pellegrino and how such absolutes can hamper good doctoring instead of promoting it. If neophyte physicians were to bow down to moral absolutes blindly, irrespective of the context and the status quo, their prudential thinking will be hurdled in that they will not have the chance to practice and develop their phronesis under the guidance of mentors and they will not be able to make the decision that is in the best interest of *this* patient at *this* moment. The point being that, alone, rules and duties will not bring about a good physician who will do the right thing even if no one is looking[60]. As Pellegrino and Thomasma state, "even if there might be agreement on a definition of the good, there is certain circularity in the logic of VE. The morally good act is one done by the virtuous person; the virtuous person is one who performs morally good acts. This circular reasoning is tolerable when some common notion of the good is accepted by all. When there is no such common notion, the logical consistency of the connections between character and morally good acts is no longer sustainable" (1993, p. 18). Thus, a justification for acts needs to be sought outside the virtues and here comes the role of principles or rules as action guides *in addition* to virtues. Virtues remain the central element for it is precisely the agent himself who will choose what principles or rules to follow. Here, one inevitable question arises: Why VE? The answer to this question lies in the fact that the view of moral education that is being taken in this thesis is that one *has to be* a certain kind of being in order to do the right thing. One of the main goals that this thesis is aiming at is to argue that character needs to be regarded as one of the aims of the

[60] Add to it the possibility that a physician might be lured to ignore the rules for consideration of self-interest and personal gain if she is sure that no one will know about her infraction (similar to the shepherd's use of the ring of Gyges referred to earlier on). The same can be said about ignoring one's duties if this can go unnoticed.

education of physicians (in addition to the skills and science that is needed from them to graduate with an MD). These traits of character are scalar qualities (that one can have more or less of) characterized in aretaic terms, and they are virtues. In addition to focusing on the moral formation of the person qua person, VE also focuses on the moral formation of the person as part of a social fabric. McIntyre spoke of the cooperation of people for the attainment of goods that are internal to those of the practice they belong to. Thus, the virtues are the qualities of the physician both as a person and a professional. And this is what we aim at bringing about. As mentioned earlier on, while rules might matter, they alone do not offer much that can be relied on because it is a matter of what kind of person one actually is that makes the difference[61].At the end of the day, rules (institutional or legal or even moral-if one is of a weak moral fiber) can be broken (misused or abused) if no one is looking because, human nature being what it is, the economic situation being what it is, life's burdens being what they are, students of medicine and physicians are, and will be, lured by many circumstances. Unless they "are" specific kinds of persons whose character will guarantee that they will be morally equipped to face the temptations no matter what, nothing will guarantee their obedience to the rules or their doing the right thing whatever that is. One has to be realistic. In contrast to Rousseau, the assumption again here is that virtues are not natural and human beings are not born good or just. Yet, in contrast to Hobbes, they are not born evil either: "Neither by nature, then, nor contrary to nature do the virtues arise in us; rather we are adapted by nature to receive them, and are made perfect by habit". (1947, p. 331) One can argue that some internalizing or truly believing in principles might have the same motivational effect as coming to acquire a virtue. The answer to this is that principles, can, at best, offer proper moral guidance to a virtuous moral agent. What guarantees that the principles one adopts are the morally correct ones?

[61] It is not about action, but about character. Once character is guaranteed, actions will naturally come about.

Is it morally right for a physician to adopt a principle stating that the "end justifies the means" when the end for her is to make more money? It is indeed not right to appeal to the principle that "the end justifies the means" when the end is a bad one. Yet, the question arises whether a morally good end can be justifiably realized via bad means. This is when matters get a little difficult. For example, it is debatable whether a lie told in the pursuit of another virtue (*ceteris paribus*, not telling a patient he suffers from a serious disease out of compassion because you know the patient well and have reason to believe that he will harm himself) is right or wrong. It remains the case that it is nearly impossible to get theoretical exactness on practical matters. The virtuous physician will have to ponder the case at hand and be aware of the particulars that construct the case (which unfortunately rarely happens in contemporary medicine where patients are most of the time treated as "diseases" or "cases' regardless of their narratives and situations. This is further illustrated in the case of Mrs. Jones below). The physician must ensure that she recognizes the facts, sees and understands what is morally relevant and make decisions that are sensitive to the demands of this particular case. Lying to a patient might not be virtuous in *all* circumstances but with this particular patient, this particular case and at this particular time, it is the virtuous thing to do. The virtues are exhibited in behavior and when facing an apparent conflict between virtues (compassionate lie) VE asks us to imagine what would the virtuous person do and act in this situation and make that person's virtues our own and, since moral judgments are often difficult and "the decision rests with perception" (1947, p. 347), one must rely on personal judgment to decide what is right. Some virtues are needed as a starting point.

Principles tend to be rigid and what is needed for a physician is flexibility in moral deliberations. Thus, moral character is acquired through education and humans (in this case, students of medicine) can be educated to become virtuous and to develop the

appropriate emotional response relevant to the situation. The strength of VE lies in that it delineates that there are no absolute rules in ethics but that ethics is a matter of practical wisdom which involves a mixture of understanding and experience; involves the ability of reading individual situations aptly; draws on previous experiences; and allows the person to constantly improve his understanding in the light of each individual situation that he faces. That person "sees" what should be done on "each" occasion. He has developed an "internal compass", so to speak. Theories that give rules are at best unrealistic for a very simple reason: there could be no such thing as a magic recipe for right action since situations vary and not two instances are exactly the same. For example absolute deontology is inattentive to the situations and state of affairs: Lying cannot be wrong in all circumstances and sticking to "absolutes" might be problematic particularly in the practice of medicine. For example, one's duty to respect autonomy (abiding by the wishes of an HIV patient not to tell his spouse about his condition) might be outweighed in certain situations by our duty to help or save others (her being infected).One might argue that some of the strengths found in VE are found in other moral frameworks such as that of W.D. Ross and moral particularism. Ross for example was equally sensitive to context. According to him, the consequences of an action (lying) may sometimes make lying the right thing to do. He differentiates between 'prima facie duties' and 'duties proper'. Prima facie duties are not absolute, but must be considered alongside other duties. Yet, insofar as prima facie duties conflict, one must decide, on the basis of contextual details, which of these duties is most pressing. The action which is judged to be, all things considered, the right thing to do, is the duty proper and we know what our duty is by 'intuition'. However, we intuit general obligations and not what is right in a particular situation as reasoning is needed. "Principlism" has taken almost worldwide acceptance and acknowledgment and is being taught in almost all medical schools as a guideline to dealing with cases laden with

ethical controversy. Yet, while one might agree on the main principles presented by Beauchamp and Childress, one might dispute the range of their application: in the case of a single pregnant women who is on drugs and who requests abortion because she cannot raise her child, the question would be *to whom do we owe the duty of beneficence, to her or to the fetus?* Another example would be the case of conflicting duties. When faced with moral dilemmas and we have a conflict between duties of equal importance, we are morally obligated to violate one duty. There are no magic recipes and such scenarios are more prevailing today as moral life is getting more and more complicated and characterized by too many particulars. Another example would be patient-centered deontological theories where "rights" matter more than "duties". Hence, a physician is warranted not to be used for moral good against her will. Should she be the only ED physician and a serial rapist was just rushed in, no virtue-talk can convince her to save the life of the patient and then turn him in to the authorities *if* she does not want to. The point is, at least in this situation, the consequences of the action are significant enough to be taken into consideration. Not doing so will, at the least, imply that the physician has betrayed the internal ends of medicine.

Indeed, Aristotle's VE has an edge over other theories, for our purposes and project, in that it primarily recognizes the fact that as human beings, we have a capacity to reason influenced by our emotions and that ethical perception consists of cognitive processes and emotional registration. Thus when faced with a patient case, the physician will perceive the situation, judge what is right and would want to act in the right way because it is now her second nature. Without this, straight obedience to rules becomes sterile in the long run. With VE the physician unravels the particulars of the case, uses moral imagination, appreciates the importance of emotion as well as reason, and uses practical wisdom which is a product of a learning process. Henceforth, it offers an inclusive framework. Consider

the case of 45 years old Mrs. Jones. She was five months pregnant when she was rushed to the ED suffering from what appeared to be a stroke. The attending physician and her team deduced that serious medical problems with the fetus are causing her illness and suggested terminating the pregnancy to save her life. Mrs. Jones refused and her decision was backed up by the chair of the division, Dr. Catharine, who looked at the particulars of this case: Mrs. Jones's pregnancy is a result of the 3rd IVF trial; she has lost her husband and cannot afford to lose this child. Mrs. Jones and Dr. Catharine fought for her fetus and both survived. To grasp the context necessitates a thorough mapping of the case in a way that allows one to see the important salient features. General rules and guidelines might be handy but it is crucial to reflect on the situation, use moral imagination, reasoning, emotion, reflection and practical wisdom. It is also important to note that, since our project is one concerned with bringing about a certain kind of physicians, character building is essential: we do not want a physician who visits her terminally ill patient whose treatment is now deemed futile because it is her *duty* but because it the *compassionate* thing to do and she embodies the virtue of compassion (mean and all). The practice of medicine places the student in front of situations that are morally different and multifaceted. Students need to "see" the moral issues intrinsic in these situations or else they will only be attuned to the "science" of the case and the internal ends of medicine will not be met. Plasticity in evaluating the case at hand by considering what would a virtuous agent do in this situation allows solutions to cases that are new, diverse and that cannot be solved by mere obedience to rules and principles. Cases like that of Mrs. Jones are emotionally laden but as Aristotle would have it, emotion is not only a manner of reacting; it is also a manner of perceiving, of being involved, and then reacting in a particular situation. Thus, to act rightly involves acting rightly in affect, it is learning to feel the right emotions in the right situation.

VE comes to the scene as a more opportune moral theory; it is timely because individuals are becoming lured to do the wrong thing when no one is watching and when they can get away with it particularly with some personal gain or with not loss to themselves. No all thinkers agree with this. For example, Louden (1984, pp. 227-236) argues that at best, VE has an auxiliary role to play and that the chief role is actually played by an ethics of rules. The main critique of VE is that it does not offer sufficient guidance to people[62], particularly when facing different and new situations (an idea discussed by Hursthouse in 'Applying VE' (Hursthouse, 1995, pp. 56-75). While it is true that VE will not provide the neophyte (or the veteran) physician with a *modus operandi* of what the right action is, yet, this is one of the virtues of VE because offering such algorithms (to use the words of O'Neill) seem to be unrealistic since the right action cannot really be codified within a formula or an algorithm as there are always many variables surrounding it. The main strength of the VE approach against the utilitarian and the deontological[63] ones for example is that it constantly recognizes that life is full of tension, that there is a plurality of goods (at times conflicting goods) and that however hard a person tries, he cannot have all the goods all the time (an example discussed earlier is 'principlism' and the controversy around the scope of the application of the main principles this theory offers). Henceforth, the fact that VE does not help us discover "the" right thing to do might actually be viewed as its strength for ethical questions are a function of the situation and ought to be continually subject to re-examination. Aristotle himself gives the analogy of the steersman.

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[62] Some critique it as being culturally relative because different cultures have different values. But this problem of relativity is not peculiar to VE since cultural disparity in character traits is not greater than the one we see in rules of behavior (thus deontology is not immune) and one can also argue that different cultures have different notions about what makes up for happiness or welfare.

[63] After all, the application of such principles or rule requires what Aristotle called practical wisdom.

The ethicist (and for our purposes, the good physician) is like the steersman trying to take a boat through a hazardous journey. He has his eyes on a plethora of things: the state of the water, the indication of the compass, the force of the wind, etc. It is the capacity to appreciate the complexity of the situation and to make a good decision that makes him a wise steersman. Simple adherence to rules and principles will not always do the trick[64] since, as it was previously argued, there could be no such thing as a magic recipe for right action in view of the fact that, for a practicing physician dealing with patients, no two patients or cases are exactly the same and even considered application of rules or principles will not always suffice, even when supplemented with additional nuances and refinements for dealing with conflicting principles and this is so because of the nature of medicine and the cases one is faced with: each patient is unique with particular needs and values. Stocker (1976) who argued that utilitarianism and deontology concentrate on rules, obligations and principles instead of persons, criticized these theories: they make harmony between reason and motive almost impossible which leads to a "malady of the spirit" causing the agent to develop a schism between his actions and motivations (1976, p.454) and are thus defective. VE, by focusing on character and dispositions of the person does not suffer from this deficiency. Rules, while useful, are not enough and Aristotle tells us that ethics is not a matter of generalization, that we must "not look for precision in all things alike, but in each class of things such precision as accords with the subject-matter, and so much as is appropriate to the inquiry" (1947, p. 319). Cases will have to be dealt with "in the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way, is what is both intermediate and best, and this is characteristic of virtue" (1947, p. 340). Learning to live a good life is a kind of extensive moral

[64] As Hursthouse puts it, "[w]hy should it be a condition of adequacy on a moral theory that it should provide an algorithm for life?" She continues saying that "[r]ather than criticizing a secular theory for failing to come up with rules that settle difficult cases, we might say that it is entirely to its credit that it does not do so." (1995, p. 61).

apprenticeship. At the beginning, one sometimes acts correctly yet, perhaps without deep sincerity. Yet, as time passes by, and as one learns[65], one becomes a person of integrity: one's actions, thoughts and feelings become synchronized. All this requires experience and practical wisdom. But eventually, this person can be relied on to do the right thing in all circumstances. Yet, is VE alone enough? It might be necessary but it is not sufficient (particularly to the neophyte who has not yet acquired enough experience and practical wisdom) and since a good deal of medical ethics necessarily ought to be about thepatient and based on *duties* owed directly to other human beings while VE is more or less directed towards the self and the cultivation of core virtues. Add to that the fact that human beings are fallible and as virtuous as a character can be, and as prudent as a person can be, this does not make him immune from errors in judgment. Thus, the language of duty and obligation come in handy *in addition to* that of virtues. VE suggests that duties will be respected somewhat effortlessly and that whenever duties conflict, the right decision will be made by the *phrominos* the student of medicine has now become. Hence, if one is to build character the way we propose it above, then one has to begin by teaching the virtues. The assumption is of course that one has identified what the right virtues are and that these virtues can be translated into attitudes: it is one thing to appreciate cleanliness and another thing not to litter. So at this point, two important questions arise. Can virtue be taught? And if yes, how?

2.4. Can We Teach Virtue?

In Plato's *Meno*, Meno asks Socrates a question left unanswered: "Can you tell me, Socrates, whether virtue is acquired by teaching or practice, or if by neither teaching nor practice, whether it comes to us by nature or some other way?" (*Meno* 70 a). Aristotle

[65] And here comes the importance of role models which will be discussed later in this chapter and in chapter 3.

answered this question: Intellectual[66] virtue can be learned (and improved) as a result of methodical instruction whereas moral virtue[67] is a matter of habituation and practice, the best practice being the imitation of a good role model. Thus, for Aristotle, virtue can be taught: while it is not natural, it is not opposed to nature either. Nevertheless, Aristotle was aware that it takes a long period of time for a moral character to develop since human beings are born with numerous tendencies and a person's ability to regulate his desires is not as easy as one might think. Shelton, arguing for the importance of teaching virtues to medical students and acknowledging the fact that modern day society is a pluralistic one which needs to respect the individual in the student sees in Aristotle's VE "guidance for medical educators" (1999, p. 672) and he proposes the use of Aristotle's framework of virtue as a yardstick for training new physicians (1999, p, 672). Wear and Zarconi (2008) conjecture that compassion and other virtues can indeed be taught to medical students and argue that once curriculum time is over, medical students rely on role modeling to learn the virtues. Still, whether virtue can be taught and if yes, whether it will make it in modern times remains a matter of much controversy. We find a similar debate in Plato's *Republic*: to Glaucon, we do what is right only under pressure while Thrasymachus argued that goodness is a charade and what matters is having a good reputation. Many modern physicians adhere to Thrasymachus' vision, and many students of medicine are *akratic* and it is precisely these physicians who are causing damage to the *profession* of medicine. Regardless of Aristotle's own vision of the development of virtue, it remains a fact that if virtue is to be taught there need to be more than one mechanism to teach it: (1) a role model (as Aristotle himself suggested) and (2) an organizational structure and culture that will allow the flourishing of such virtues.

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[66]Science, art, practical wisdom, intuitive wisdom, theoretical wisdom.
[67]Plato's cardinal virtues, namely, wisdom, justice, fortitude and temperance. In this thesis, when reference is made to virtue, it is primarily moral virtue.

2.4.1. Role Models:

A role model can be defined as someone who "teaches primarily by example and helps to shape professional identity and commitment through promoting observation and comparison. Unlike mentors, role models may have only brief contact with physicians in training and do not so much deliberately mold students as inspire by their own conduct" (Reuler et al., 1994, p. 335). As stated by Wright and Carresse, "physician role models affect the attitudes, behaviours and ethics of medical learners and foster professional values in trainees. They also influence the career choices of medical students" (2002, p. 638). Aristotle's VE relies significantly on the effects that role models have on human beings. One of the main tenets of Aristotelian philosophy is that people learn by emulating moral exemplars. Since people learn by practice, the best practice is to imitate role models. It is in that sense that through a process of continuous imitation of the virtuous physician, the student becomes habitually virtuous himself. Henceforth, the virtuous physician will model the good behavior and will also be able to explain the reason for behaving the way she did to the neophyte physician. It may appear from this that it is action, rather than character, that is the primary means of instilling desirable character traits in others. However this is not what is intended here. Character is fundamental and with the established veteran physician, actions emanate from a firm character. The practice of medicine requires the exercise of reasoning and judgment in clinical as well as ethical capacities, and phronesis cannot be taught. It is basically practical understanding *in situation* which involves a lot of deliberation on the part of the phrominos. It is, after all, "the work of the man of practical wisdom, to deliberate well" (1947,p. 431). Thus, it cannot be attained outside the experience in which it plays a role. Being a role model, and having chosen to behave the way she did based on knowledge, experience and phronesis, the physician is able to explain and willing to clarify the reasons for her choice to students

so as to ensure they understand the reasons why she behaved that way. This will give opportunities for discussion and reflection and hence will improve learning. Students will thus have a chance to develop their own phronesis with time and under the guidance of a dedicated role model. Thus, ends are set by character and phronesis allows us to pursue that end: "choice will not be right without practical wisdom anymore than without virtue; for the one determines the end and the other makes us do the things that lead to the end" (1947, p. 442).

Students identify role models, they sense the enthusiasm, passion and honesty which is evidently contagious. They can identify role models easily. Wright examined what residents look for in their role models. With 230 questionnaires distributed at the University of McGill and a response rate of 85%, he found that "aggregate responses of all residents showed that clinical skills, personality, and teaching ability were ranked as the top three factors by over 90%" (1996, p. 291) and concluded that "attending physicians who are excellent role models need to be identified at all institutions so that they can be selected to spend more time with medical students and residents" (1996, p. 292). Teaching psycho-social skills was also viewed by students as great faculty role modeling (Wright et al., 1998). In another study, Wright and colleagues note that medical students identify role models in medical school and that the identification of these role models is powerfully linked with the student's choice of clinical field in residency training (1997). Indeed, a study by Mutha et al. supports Wright's studies and states that "for some of the students, relationship with positive role models had influenced their career specialty choices" (1997, p. 638) yet, they continue to say that "negative role models, in contrast, had strong dissuasive effects on specialty selections. The reported attributes of these individuals included difficult personalities, perceived lack of camaraderie, professional dissatisfaction, and disheartening physician-patient interactions" (1997, p. 638). Still, in yet another

article, Wright et al. (1998) present challenging proof in support of the claim that many physician-teachers do not show the professional characteristics that residents aspire to imitate. Yet, nothing guarantees that students will not choose the wrong role model. An ER physician who constantly asks his interns to sign her name on every patient who is admitted to the ER to get an ER fee even without her seeing the patient is hardly a good role model. But, to a student who comes from an economically deprived family, whose moral values are still not strong, this is a good role model: she makes good money without really hurting the patients! For others like Maheux et al., role models might not be efficient at all (2000). Still, the question that arises here is about the reason behind this lack of professionalism[68] on the part of physician-teachers and the importance of coming up with solutions. Examples of such solutions would be the need to develop a programme that develops the moral character of faculty that seems to suffer moral erosion. The reason for this moral erosion will have to be assessed and the means of addressing it will have to be sorted out through lectures, group discussions, grand rounds, workshops and the like. Notwithstanding, it remains a fact that human beings can acquire good and bad habits from role models and that one can ultimately learn from both the good and the bad. The good role model remains the *phrominos* to be emulated. *Phronesis* allows for deliberation and judgment in difficult moral situations. In it, intellectual and moral virtues are united. Indeed, one of the criticisms presented against VE is that it is deficient because it is not *action-guiding*[69], and that "it lacks the capacity to yield suitably determinate action guides", particularly in new scenarios (Solomon 1988, p. 432). One can stipulate that it is precisely this crowning virtue that will allow a person (or a physician) to make the choice

[68] Professionalism here is used in the sense of belonging to a profession and hence making a public promise to do that which is right, to serve the patient, to commit to a life other than self interest, etc.

[69] Further criticism includes: leaving its agent to moral luck; being egotistical and concerned only with the agent; not offering solutions in conflicting cases.

of action that he must make for the good of the patient. Moreover, considering the role of habituation and imitation in the acquisition of habit, is it not that observing a role model and wanting to emulate him and become somehow another Osler or Peabody in itself action guiding[70]? Also, one can argue that it is precisely when the physician acts having the ends of medicine in mind, her virtuous character becomes itself action guiding.

According to Pellegrino and Thomasma, "[t]he power of a faculty model to shape behavior for good or evil is enormous. It far exceeds the power of a lecture or course in ethics. This power generates a serious *de facto* obligation for faculty members and medical schools to be critical of the value systems they express and transmit" (1993, p. 177). Still, it is my contention that role modeling alone does not suffice. Moral exemplars – be they silent (those who do not speak but simply act) or expressive (those who explain while they act) - are necessary (and indeed indispensable) yet not sufficient for the making of future virtuous physicians. As Pellegrino and Thomasma themselves state, "though the best way to teach virtuous behavior is by example, some significant headway can be made by teaching ethics as a discipline" (1993, p. 179), yet, "there is no guarantee that a knowledge of ethics itself will make people virtuous" (1993, 179). I will come back to this issue in chapter 3.

2.4.2. Organizational Structures and Culture:

Medical students do not become virtuous in a vacuum. Learning and habituation take place through participation in an environment where a certain way of being is modeled, where a certain consistency between what is said and done is exhibited. Inconsistencies, like in the case of the obstetrician portrayed in chapter one can have deep effects on the student, often

[70] Athanassoulis argues that the virtuous person is an exemplar and that "[i]f virtue consists of the right reason and the right desire" it will be action-guiding (2006).

function as strong teaching tools, and are hard to undo. In addition, virtues and ethics need to be integrated throughout the teaching hospital. This latter point will have to reflect a certain culture, a system of shared values and beliefs that promote ethics and professionalism or else students will experience a kind of moral and intellectual schizophrenia: "*Do as I say, not as I do*" is not the best way to help neophyte physicians internalize the virtues of a good physician. The physicians, staff, administrators, control systems, the entire bureaucratic composition interacts in such a way as to make up the behavioral norms of the institution. As Pence puts it, "[m]orality is not learned the way one learns to play a flute or to do a tracheotomy by observing a 'master' proficient in a certain craft or technique. Compassion similarly is not learned from a Master of Compassion (or the chief role-model thereof). Instead it is developed or not by the 'shape' of the medical environment in which students learn medicine. The overall medical context in which students thrive or stagnate is more important than the efforts (however noble) of any one individual" (1983, p. 190). Virtues will have to be nourished by the organization, the mini-society in which students learn and thrive. Ultimately, it is the general culture of the institution which affects everyone and helps mould characters creating a certain ethos particular to an institution. This general ethos engulfs members like a tsunami. Members blend in, to the extent that one can recognize to which institution they belong in terms of their ethos. The parts make the whole and the whole affects the parts. The institutional structure is responsible for a certain ethical profile precisely because the parts make the whole and the whole assumes an identity of its own which affects the parts. Consequently, minute details count. This is one form of the hidden curriculum of which more will be said in chapter 3.

One might contend that the virtues (or vices) of students are already fixed prior to their entering medical school and hence it is useless to speak of teaching virtues. One might

even argue that this talk of teaching the virtues is too idealistic and will not withstand the test of modern times, that is the question whether one can be moral in an immoral world? To this I answer that we cannot (and indeed should not) afford to be otherwise. Although moral perfection, or complete virtuosity, cannot be achieved, it can be set as a framework, a goal to be pursued. Simply because one could not get the Nobel prize in literature does not mean that one should stop writing. How many students of music give up the piano because they could not master Tchaikovsky's first piano concerto? The closer one gets to the goal the better one becomes. Whether virtues can be taught and if they can, whether they should be taught, are two questions answered in the affirmative. The need to teach virtues and to help students internalize them becomes more evident and pressing as studies reveal that often medical students enter medical school with a form of idealism that usually gets dissipated as they move on from year to year in their medical training. Branch et al. found out that students start out having strong empathic identifications with patients, an empathy which leads to respect and compassion (1998). With time, students start witnessing what came to be referred to as "moral erosion". Evidence is provided that moral change takes place during medical school although in the wrong direction (Branch 2000; Feudtner & Christakis, 1994; Lind 2000; Sheehan et al., 1990). Moral change, in one direction or the other, illustrates the plasticity of the brain: selected areas in the brain exhibit a mechanism of neurogenesis which continues throughout life, including old age. Stimulation in the form of an "enriched environment" in aging experimental animals (an environment with a lot of areas, objects to explore, etc.) enhanced both neurogenesis and performance. FMRI studies on humans have also revealed evidence of plasticity with acquisition of new functions in new areas in a number of situations in adults. Consequently, the view about continued plasticity and learning and acquisition is substantiated by scientific data (Tonchev et al., 2003; Abrous et al., 2005; Zhang, 2005).

Several research studies were released about this topic. If alterations happen in one direction, they can happen in another.

In this chapter, a brief account of Aristotle's VE has been presented since it is my contention that some of the ideas present in Aristotle's *NE* can be used as a guide by medical educators to develop the character of the neophyte physician. I also discussed the making of the good physician and the shaping of the moral character of the student of medicine and argued that this can be done by instilling "core virtues" by means of habituation which will eventually be internalized, thus leading the physician to realizing the ends of medicine and living a happy life. I maintain that if virtue is to be taught, there need to be role models in medical schools and attention paid to a sustained organizational structure and culture that allows for the development of the virtues.

The central question then becomes *how to ensure that change takes place in the right direction and the moral erosion of future physicians is avoided?*

Chapter 3: THE MORAL DEVELOPMENT OF THE MEDICAL STUDENT AND THE CURRICULUM

"A hidden curriculum is not something one just finds; one must go hunting for it." (Martin, 1994, p. 158)

During their clinical rotations, medical students face a variety of cases that pose ethical dilemmas. Some of these include, but are not limited to, mistreating patients in the *Outpatient Clinic Department* without explaining to them what the diagnosis is; asking for unnecessary tests; taking photos of patients in the operating room after becoming anesthetized without their prior consent; and discrimination in dealing with first and second or third class patients. For these patients, ideally, the same service is provided but it depends on the patients' income and the premiums of insurance they can afford. In the hospital setting, the second or third class patient shares the room with another patient and therefore pays lower rates for hospital services while the first class patient has a room for himself and pays a larger amount of money.[71] Students often feel as if they are suffering from what I might call "moral schizophrenia": they are told to behave in one way, but see their attending physicians (whom they are supposed to emulate) behave in another.

[71] The major difference would be in terms of the sum of money the patients will have to pay when at the hospital. The first class/third class category is mainly for in house patients. Ideally the service should not differ but in reality it does. Thus, the second class or third class patients would pay less for their bed per night at the hospital and the charges for blood tests, X-rays, pathology, medications, etc. would be less. The beds these patients have are not in a private room and patients share a room and bathroom with another patient.
For out-patient clinics there is really no difference, if they want a private attending they would come to private clinics and see whomever they want and it is a fixed payment by the hospital. If they are from a low socio-economic class then they would go to what is known as the Out Patient Department where they are seen by a resident first and then by a faculty (if they are lucky enough). Here also the rates for labs and so on are reduced.

Medical students jump enthusiastically onto the wards, proudly wearing their white gowns (and what they stand for) only to see that what actually takes place is not what they have been learning in their ethics courses. What is wrong with medical education? What will happen to these neophyte physicians if they continue to be inundated with such dealings and experiences? At the end of chapter two, the question of *how to ensure that change takes place in the right direction and avoid moral erosion of future physicians* was raised. In this chapter, I look at the different types of curricula that play a role in the making of the future physician. While it is my contention that the formal curriculum is pivotal in the formation of the future physician, I argue that it is not sufficient for making the virtuous physician. The hidden curriculum is far too important to be neglected and as such may play a crucial role in ensuring that changes take place in the right direction and that moral erosion of future physicians will be avoided. I also argue that currently, the hidden curriculum is having a negative influence on students of medicine who find themselves being taught one thing during the formal curriculum and yet receive different concealed messages from the hidden and the informal curricula. Thus, I will start with a general definition of the different relevant forms of curricula only to move on to an analysis of each in an attempt at showing their roles in the making of a future physician. I shall argue that the formal curriculum is wanting and that medical schools should pay more attention to the informal curriculum if they want to ensure that future physicians will have the necessary character traits that will allow them to do the right thing even when no one is looking. In doing so, I will take the example of one particular unit of medical education, namely the physician-patient relationship frequently emphasized in medical education and ethics courses. I will also argue that a curriculum change (formal and informal) alone will not work unless organizational changes go hand in hand with this endeavour (an idea already alluded to in chapter 2).

3.1. The Curriculum**:**

Medical students matriculate into medical schools in the hope of learning how to become doctors. Most matriculation criteria in Lebanon and the USA are based on their scores on MCATs and their undergraduate grade point average (GPAs). However, evaluation of suitability to medical school should not be limited to academic capabilities because one can be quite good academically yet suffer from a lack of moral qualities or worse, show evidence of bad moral qualities. Jordan Cohen, president of the Association of American Colleges in 2002 communicated concerns:

> the way we pick students for admission is the imbalance that currently exists in how we convey to applicants the selection criteria we use. I'm referring, of course, to our tendency to underemphasize, because they are harder to measure, the personal characteristics we are seeking in our applicants and to overemphasize the more easily measured indices of academic achievement (2002, pp. 476-477)

and he dared the medical community to "help devise better tools for evaluating students' personal characteristics" (p. 477).

Indeed, according to Salvatory (2001), there is enough evidence in the literature that the performance of students in the first two pre-clinical years of medical school is sufficiently predicted by these purely academic scores. Medical schools offer a variety of curricula that aim towards graduating skilled physicians, all having in common a core curriculum in basic and clinical sciences. Still, Murden et al. (1978) and Bascow et al. (2000) have found a strong correlation between non-cognitive measures and clinical performance which makes one ponder the importance (and possibility) of assessing character traits in admission to medical schools (assuming it can be done). As mentioned in chapter one, there are a myriad of character traits that medical schools deem desirable in physicians and these are often qualities that reflect the schools' mission and objectives as well as the

culture (Albanese et al., 2003; Reiter and Eva, 2005). Yet, in the absence of such assessment criteria, what is to be done? Should all students of medicine who matriculate be allowed to graduate if and only if they meet the curricular requirement or should their ethical behavior or character be a factor in their graduation (or denial of it)? A study revealed that cheating in medical school is linked to cheating later on (Tolkin & Glick, 2007). A medical student who cheated during her final examination was allowed to graduate, "despite being caught red-handed" (Laurance, 2000). In an editorial in the *West Journal of Medicine*, "MSMW" states that frequent cheaters are likely to be incorrigible and that "[i]n the professional and public interest these should be exposed and expelled from the school or from the profession, even at the expense of the time-consuming and costly legal actions that are almost certain to ensue" (1982, p. 145). The less frequent cheaters should be educated and counseled. In an editorial to the same journal (1982, p. 77), Lasnover M.D. recounts a story that made him pessimistic about cheating and its effect beyond medical school and states: "This rampant display of dishonesty by one of my colleagues turned my stomach." (p. 77) He had witnessed a fellow doctor forging signatures that entitled visitors to enter a draw for a portable television set whilst attending a scientific and commercial exhibit. Lasnover concludes by saying: "my experience leads me to doubt the conclusions stated in your editorial. I shudder to think that whereas only a small number of our colleagues behave in such fashion, the numbers may increase in the future" (p. 77). How should a medical school handle cheaters? Should such students continue in medical school and should one accept students who have a character flaw to begin with? Can this flaw (in its degrees) be assessed from the beginning upon admission? Can one rehabilitate the moral fiber of the matriculant? These are important issues. The curriculum in its several components and kinds plays an important part in managing them.

To begin with what is a curriculum? It is not easy to find a clear and comprehensive definition of such a widely used term. While Sockett warns his readers: “Seek not for any definition of curriculum. There is no such elixir” (1976, p. 88), Beauchamp attempted to define it by saying that a curriculum is “a written plan depicting the scope and arrangement of the projected educational program for a school” (1982, p. 25). Stenhouse, on the other hand, gave a holistic explanation and argued that a curriculum is “everything that is happening in the classroom, department, Faculty or School, or the University as a whole” (1975, p. 2). Kern et al. (1998) define a curriculum as “a planned educational experience” (1998, p.1) and Rogers argued that the

> curriculum is often seen as a body of knowledge, the content of education to which the students need to be exposed. But curriculum is much wider than a list of subjects to be studied; it is not only what you say but how you say it! Curriculum is all the planned experiences to which the learner may be exposed in order to achieve the learning goals. (1996, p. 176).

Notwithstanding these definitions (or lack of them), the curriculum is much more than what is given in the classroom by the faculty. It extends far beyond that to encompass that which is not said or taught. The curriculum can be said to be everything that occurs in the medical school and more. Thus, the curriculum in medical school is like a fine Persian carpet. One incorrect loop can impair its quality and beauty. Consequently, no one will buy it. In addition, it will damage the reputation of the entire Persian tapestry industry.

Leslie Owen Wilson (Curriculum Index, 2005) professor of education at the University of Wisconsin-Stevens Point listed and defined eleven curriculum types among which are the curriculum-in-use (formal), the informal, the societal and the phantom. There have been efforts in the last decades to reassess the medical curricula with their traditional emphasis on basic sciences and clinical medicine and to add a number of bioethics courses in the

hope that they will help shape the moral compass of students and sculpt their moral fiber[72]. A few years back, a physician at Johns Hopkins said: "Today, doctors are both more powerful and more deaf. They are far less helpless in the face of suffering, yet they often cannot hear the cries that evoke no possibility of remedy. A more humanistic education might heal the physician's deafness" (Overby 2005, pp. 25-26). Mastery of technical skills and scientific knowledge are necessary to becoming a good physician but they are not sufficient. Doctors and the public are becoming more aware of the moral expectations of physicians and the public is becoming more and more disenchanted with their moral fiber as noted in chapter one. The American Medical Association emphasized the importance of teaching ethics (and developed a Unit for teaching it), the General Medical Council of England identified ethical behavior as a crucial component of education and the British "Pond Report" (Institute of Medical Ethics, 1987) endorsed the integration of a broad course in medical ethics within the curriculum of UK medical schools and that "time should be set aside within existing teaching for ethical reflection" (Gillon, 1987, p. 115). Ethics teaching has become part of integrated medical curricula over the past years because of the belief that such training plays a role in the shaping of character. These programs have more or less similar aims, described by Miles et al. as aiming to "develop physicians' values, social perspectives, and interpersonal skills for the practice of medicine" (1989, p. 705). Modern schools of medicine are resorting to modern styles of teaching. Some have recourse to computer based teaching, and audiovisual aids to exemplify the importance of virtues. The movie *The Doctor*[73]based on the memoir of real-life surgeon Ed Rosenbaum,

[72] It is important to note that I am not advocating indoctrination which is detrimental to healthy thought. Indoctrination is blind absorption of virtues while inculcation is accepting them with reflection and critical thinking and eventually accepting them as one's own because one is convinced that they are right and good. The phrominos reflects and thinks before making a decision.

[73] The movie portrays a doctor who cares little for the emotional and psychological wellbeing of patients. As the movie unfolds, we see him diagnosed with a tumor. At this

entitled *A Taste of My Own Medicine* is one example. This is all part of the formal curriculum.

3.1.1. The Formal Curriculum and the Making of a Good Physician**:**

The formal curriculum is the declared and usually written curriculum. It is defined by the UNESCO education department as being the "the planned programme of objectives, content, learning experiences, resources and assessment offered by a school. It is sometimes called the "official curriculum" (UNESCO, 2010). The guiding principles of offering ethics in the formal curriculum is that, as a discipline, ethics plays a role in high quality patient care and professional behavior. Back in 1910, Flexner, to whom the change in twentieth century medical education is owed, maintained that in contemporary life the medicalprofession is an organ distinguished by society for its highest goals and that it is not a business that one should exploit. (Flexner, 1910). The same can be said of the medical profession today. Only, in the US in general, and at the time of the Flexner Report, several medical schools were proprietary schools that worked for profit much more than for education. With the Report, the change was towards a medical education that emphasized strong biomedical sciences along with hands-on clinical training in an attempt at graduating skilled medical practitioners. Notwithstanding, Flexner did not overlook the humane face of medicine: in addition to the fundamental sciences, he referred to the indispensable insight and sympathy of physicians and acknowledged that scientific progress has tremendously modified their ethical responsibility (1910). The same idea we find echoed years later with Pellegrino (1974) who argues that while skill and craft are

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point, the change begins and he metamorphoses from an arrogant physician to one that cares for his patients and teaches his students to do the same.

essential to the physician, they are not enough. To Pellegrino, without humanism, physicians are deficient practitioners. Today, the revolution ahead of us is one that aims at graduating skilled physicians with a sense of morals because this is precisely where the inefficiencies lie. Formal education (communication skills, bioethics, etc.) alone will not make students morally better physicians. Nowadays students of medicine as well as physicians are faced with myriad ethical concerns during their medical training and practice. These include disagreements between patients, relatives, and healthcare professionals over treatment options, difficulties in obtaining informed consent, medical error, confidentiality, and others. As such, it is often argued that students of medicine should be well trained in clinical ethics and that practicing physicians should have at least a minimum level of ethical sensitivity and critical analysis that allows them to deal with complex cases. In an attempt at ensuring that, most medical schools around the world have introduced courses and programs in bioethics. These include lectures on the nature of moral discourse and in moral theories. However, students of medicine often remark that there is a gap separating theories offered in ethics from concrete moral dilemmas they face on the wards. Thus, statements like "how will deontology help me decide on whether the life of the baby is more important than that of the mother?" or "ethics is great but really, it is a theoretical exercise that has no practical bearing to me" are becoming catchphrases that reverberate often when bioethics courses are given. This problem became less pervasive as case-studies started being used in an attempt to add to the abstract theories taught to medical students hoping to enhance their ethical reasoning and moral sensitivity. Nevertheless, these vignettes are mostly presented as an addendum to a unit or a theory and often engage the students "temporarily" and do not allow room for a convincing rational conclusiveness as many details are left out from the picture. These absent details are vital in assisting the decision maker weigh the relevant considerations of the case. Students

leave the debate confused, often forgetful if not skeptical of ethics and its bearing. In an attempt at remedying this, several modes of ethics teaching have been introduced to the formal curriculum: Lectures, seminars, case-based analysis, debates, problem based learning (Parker, 1995; Tysinger et al., 1997), role play (Nelson et al., 1991), and narrative ethics (Jones, 1999). Teaching in the formal curriculum entails that professors consciously play the role of good role models, use deliberate reflection, convey accounts that involve patients, doctors, staff and other members of the healthcare team. These attempts can perhaps make some students more ethically sensitive to a number of issues, but will not necessarily make them act in the right way. Thus, a student can learn that he ought to respect autonomy yet actually override it; know how to respectfully greet a patient yet act with arrogance. In other words, the emphasis in ethics courses is rather on teaching the students the skill of identifying and analyzing moral problems in an attempt at solving them. However, something else is needed to bridge the gap between theory and practice that will allow the student to behave in a certain way and to be a certain kind of person. Pellegrino discussed seven questions he encountered from critics related to the teaching of medical ethics. One such question was whether teaching medical ethics makes a difference (1989, p. 701). Pellegrino answers that no proven link existed either between the teaching of basic sciences and clinical behavior and thus ethics should not be singled out in that respect. Yet, he does refer to a study (Pellegrino et al, 1985) which revealed that physicians who took courses in ethics "perceived themselves better prepared to make the ethical decisions they confronted in daily practice" (1989, p. 701). His answer to the question whether ethics can be taught was in the affirmative although he comments that the teaching of ethics is not "expected to guarantee virtue" (p. 702). Moreover, and perhaps what is even more serious, is that students often witness the physicians who teach them the concepts and notions necessary for good behavior actually break them themselves. A

typical example is a case reported by a student in his second year of medical school in a renowned teaching hospital who was shadowing one of the physicians for 75 minutes. He came back flabbergasted at the physician's lack of communication skills and sensitivity towards the patients he had been seeing, particularly for not giving the patients enough time and for making sure to ask every patient to pay the bill by abruptly telling them it is the time to end the visit. What shocked the student even more is that this physician is the one who teaches them the Communication Skills course and who has served for some time on several ethics related committees.

It can be argued that past incidences of ethical infractions and misconduct as well as rapid development in biotechnology can be avoided if neophyte students of medicine were given courses, or had proper instruction, in bioethics. This is, to some extent, a legitimate claim if one is willing to argue that the past mishaps would not have happened had the culprit been aware of proper ethical conducts and of major ethical theories. Yet, this argument does not hold. Typical examples can be taken from the realm of research ethics: The Nuremberg Code, which marked the beginning of human subject protection and was the basis for human subject research ethics actually came about as a consequence of war crimes and the resulting Nuremberg trial in 1946. It did not curtail scientists from breaking it and this was evident from the well known Willowbrook Hepatitis experiment carried out in 1956 in New York state on mentally challenged children. More recently, after the prominent Belmont Report in 1979, we have witnessed several infractions like the Jesse Gelsinger Gene Experiment at the University of Pennsylvania in 2000 and the John Hopkins "Mechanisms of Deep Inspiration–Induced Airway Relaxation Study" (Steinbock, 2002) which led to the death of the volunteer Ellen Roche, in 2001. Unless one is willing to contend (and prove) that the persons involved in the above mentioned infractions were oblivious to any ethical constructs, then one should be willing to contend that much more

than simple knowledge of ethics is needed to ensure that one does the right thing. Consequently, perhaps a new report (à la Flexner) should be developed advocating a change in medical education. The need for a major redesign of the content of medical training is becoming more pressing with time particularly with the rapid development in medical technology. However, curricular reform is never uncomplicated or trouble-free as there are always problems to be envisaged and battles that arise from a feeling of territoriality are to be anticipated. Thus, the challenge lies in incorporating content into the curriculum in a way that emphasizes its weight relative to the other core curriculum content (this is tied in to the issue of organizational culture referred to in chapter 2 and to which I will shortly come). Nevertheless, there are many efforts in that direction (Anon, 1984; Education Committee of the General Medical Council, 1993; General Medical Council, 1998; Mennin et al., 1998; Davis et al., 2001; Pascoe et al., 2004). Indeed, according to Swick et al., among the 116 US responding medical schools which he studied, 89.7% of the schools reported giving some formal training related to professionalism[74] (Swick et al., 1999). Yet, they argue that "the strategies used to achieve that goal appear inadequate" (p. 832). Thus, a challenge lies in finding the appropriate faculty (and means) to teach the curriculum.

Consider the following case: M. is a medical student in her third year and is currently rotating on the floors. As part of her medical curriculum, she is required to take a bioethics course which runs through the entire academic year. Thrilled for having the chance to work in the Emergency Department (ED), she witnesses an incident where theories clash with practice: a 13 year old boy walks into the ED limping, aided by his father. As she approached them, the latter explains to her that his son had sustained an injury to his ankle

[74] Often defined as the behavior of physicians and how they behave during their interactions with patients and society.

while playing soccer. They wanted to be reassured that the ankle is not fractured. He was charged a good amount upon entering the ED, and was a self-payer with no insurance. The student examined the patient with the resident in charge. The ankle was swollen and very tender, indicating a possible fracture. They hence requested an X-ray. She printed the request paper and started walking towards the father to ask him to get it stamped at the cashier when she was intercepted by the attending physician asking her about the case. After she explained the case to him, he gave her a pinkish piece of paper "that he never fails to give to every single patient". The patient objected to the new additional exorbitant fee. The student had to reply: that is the attending physician's fee – even though the latter had never seen the physician. Situations like this one, and they are too many, make one wonder about the effectiveness of the formal curriculum (in terms of time and content) in helping shape the character of students. Yet, there is little to almost no proof that the different pedagogical interventions used, however varied and creative they are, do change behaviour, and hence make a physician behave more ethically (Boon et al., 2004; Tamblyn et al., 2007). This is not to say, however, that the formal courses offered are useless: after all, almost all students who have taken the course are aware of the principles of medical ethics, take into consideration the autonomy of patients and make an effort to factor in the principles whenever faced with conflicts on the wards. The question is how deeply ingrained in their character has ethics become? Osler saw the importance of linking character to medicine and spoke to his students about the profession of medicine as being unique among others:

> You are in this profession as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow-men. Once you get down to a purely business level, your influence is gone and the

> true light of your life is dimmed. You must work in the missionary spirit, with a breadth of charity that raises you far above the petty jealousies of life (Osler, 1907).

Medicine, some might argue, suffers from the absence of codified oslerian presence. Yet, this is not the case since Percival wrote a formal treatise laying down what he called the "code of institutes and precepts" for the professional conduct of physicians, which he dedicated to his son. Lessons and lectures in ethics do have their role to play but, to many, they are far from being able to capture the complexities of ethical life on the wards or to leave a long-lasting imprint on the character of the physician-to-be. Authentic education cannot happen if students are taught one thing during lectures and witness the opposite during rounds. The result may be a kind of cynicism or a process of moral erosion: a decline in moral reasoning during medical school years as shown by Branch (1998) and others discussed below.

3.1.1.1. Medical School and Moral Erosion:

The reason for speaking of moral erosion to begin with is that students matriculate into medical school already having one form of ethical self or another (unless they are morally dead to begin with). Some argue that they begin medical school imbibed with idealism and with a strong sense of empathy and identification with their patients (Branch et al., 1998), an empathy which "may be a bulwark against the emotional erosion of difficult times to come" (1998, 362). Branch maintains that students of medicine "feel trapped between the need to live according to their moral principles and the many perceived pressures to suppress their principles in order to fit in as team members" (2000, p. 504). Many would agree with this. Still, one question remains: if principles change, were these principles to begin with or accidental characteristics attached to the self of the person holding them?

The assumption being that, principles, once acquired, are there to stay. They are not accidental, a function of context and suitability. A study by Feudtner et al. about the perception of medical students a propos the ethical dilemmas they face during their medical training years, revealed that certain dilemmas influence the students and are detrimental to their moral progress (1994, pp. 670-679). These include observing unethical behavior by other team members, trying to be a good team player and not daring to rock the boat, being evaluated by means of grades, developing personal relationships with the patients more than the remainder of the team, and being slyly coerced to put oneself at risk of personal injury -such as skipping universal precautions whilst carrying out a procedure (p. 670). They report one student saying: "Slowly I'm seeing my classmates become 'destroyed' and it scares me! I've become so cynical that it's just not right!!" (p. 675). The authors conclude that ethical education as presently taught is "ineffectual" (p. 678) and that what is needed is the fostering of ethical standards (p. 678). Another study by Wolf et al., revealed that "developmental stressors" of medical education affect the students (1989, pp. 19- 23). Coulehan and Williams contend that as they matriculate into medical school, students are "good seeds" but "the lack of nourishment and the exposure to defoliants they encounter in medical training (…) alters [their] beliefs and value system so that a "commitment to the well-being of others" either withers or turns into something barely recognizable" (2001, p. 599). In their longitudinal study on erosion, Hojat et al. came to the conclusion that

> the escalation of cynicism and atrophy of idealism has long been recognized as part of students' socialization in medical school and their adaptation to a professional role. This downward trend has also been observed in the ethical erosion of medical students during their clinical training (2009, pp. 1189).

They conclude by saying that profound changes to enhance empathy during medical education should be considered by leaders in medical education a mandate, not an option, if the public is to be served in the best possible manner" (p. 1190). Obviously, medical education is playing a role in the shaping of the medical student's character. Some have argued that it is dehumanizing, inflexible, discouraging and, at times, offensive and abusive (Pfifferling, 1980; Knight, 1981; Sliver 1982; Weinstein, 1983; Rosenberg and Silver, 1984). Indeed, studies revealed that abuse (verbal or otherwise like embarrassment, intimidation, undermining of self-esteem) of medical students can be among the seriously traumatic and upsetting, let alone demoralizing, characteristics of medical education (Silver, 1982; Rosenberg and Silver, 1984). The study done by Wolf et al. revealed that most students saw themselves as becoming more cynical during their education years (1989, p. 20). They also reported that they developed a concern about making money. Testerman et al. speak of a process of "traumatic deidealization": the professional socialization experienced in medical school which leads students of medicine to developing a sense of cynicism (1996, p. S43). The authors speak of two models that explain the rise of this cynicism: the first model is the "intergenerational transmission" model where cynicism is seen as a learned response to abusive behaviour and maltreatment from superiors, and the second model is the "professional identity" model. This latter is explained as a temporary product of the harsher aspects of the professional socialization process. Here the student fights to build his identity in an environment filled with challenges and ethically dubious constructs (1996, p. S43). They conclude that "[m]edical students begin their training with altruistic motives and idealized concepts of health. As inexperienced and powerless members of the health care team, however, students may develop cynicism as a means to manage their environment" (1993, S45). Thus, we now speak of the pre-cynical years rather than the pre-clinical years. Authentic education does

not happen if professors argue for the importance of ethics while the organization does not worry about its being put into practice. Bruce et al. argue that the result of their study (2008, p. 244-249) implies that student empathy is influenced by medical education and that medical students become immunized against humanistic values after they matriculate into medical school. Here comes the importance of what I call the 'clandestine curricula' and what medical sociologist Hafferty has designated more specifically as the "hidden curriculum" (HC) and the informal curriculum (IC).

3.1.2. The Clandestine Curricula**:**

The issue of curricular reform is becoming more important every day. More so with the rapid development of medical technology and the ethical issues it is bringing about, which, in turn, is making biomedical ethics an important topic that cannot be brushed aside anymore. Bioethics are no longer a luxury; they are becoming more and more a core subject matter in several medical schools. Yet, much of what is learned is taught indirectly, outside the formal curriculum that the school professes to teach.

The teaching milieu in general and, for our purposes, in medical schools, consists of a number of different yet interrelated elements. At the center there is the observed and clearly stated curriculum, generally known as the formal curriculum. Yet, there are also two other areas with equal (if not greater) impact: the hidden curriculum and the informal curriculum. These are clandestine curricula yet they exert enormous power on the teaching and learning environments of the medical school. According to Hafferty, the *hidden curriculum* is the "set of influences that function at the level of organizational structure and culture" (1998, p. 404) whereas the *informal curriculum* is an "unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students" (1998, p. 404). It is my contention that the hidden and the

informal curricula play a crucial role in the making of the physician, much more than the formal one. Indeed, I will even venture to argue that the informal curriculum can either undo or enforce much of what the formal curriculum teaches. I will begin by exploring the hidden curriculum and will then move to the informal curriculum.

3.1.3. The Hidden Curriculum*:*

The HC consists of the unnoticed set of influences working alongside the structure and culture of the teaching and learning milieu. According to Cribb, the hidden curriculum summarizes the "processes, pressures and constraints which fall outside of, or are imbedded within, the formal curriculum, and which are often unarticulated or unexplored" (1999, p.197). Hence, medical education turns out to be a cultural concept affected by societal factors and internal belief systems. The term "hidden curriculum" is said to have been formulated by Jackson in 1968 who argued that in order to succeed in schools, students must learn to conform to the formal and informal rules of the school and these include beliefs and attitudes propagated through a process of socialization. The same applies to medical schools. Students learn by being exposed to hidden messages often propagated by the institution and this is precisely why the medical school is viewed as a moral community where everything matters and has consequences. Thus, the way rules are framed, policies are drafted, walls are decorated, residents and physicians walk, talk, and dress matters. It all has an effect on the making of the future physician: Walking can be a lesson in humility or in arrogance; talking a lesson in modesty or high-handedness; dressing a lesson in reticence and cleanliness or in showing-off and messiness. It is all about what kind of physician one ought to become and this is strongly related to the hidden lessons and the hidden curricula as nothing happens in a vacuum. This is precisely why a

very thin line separates the hidden curriculum from the informal one. Notwithstanding, one important matter of concern to the hidden curriculum is what the medical institution claims it cares about when it introduces formal courses in ethics and what actually happens at the level of the organization.

3.1.4. Curriculum Development, the Hidden Curriculum, and Organizational Culture*:* Instilling the culture of ethics in medical school cannot happen if the organizational culture in that school does not encourage ethics. To work on curriculum development which has ethics as a major component means that the organizational environment of the school has to support this newly emergent culture, or else, it will not survive. This calls for a paradigm shift, one that needs to happen slowly and smoothly or else it will backfire. To Kuhn, a paradigm is an exemplar, a sort of an archetype worthy to be imitated as it exemplifies a rule. In Kuhn's historical perspective, the development of scientific thought does not happen in simple linear progression where one idea is built on others, until a specific agreed-upon conclusion is reached. Instead, there is often a kind of rivalry of hypotheses and theories held by different groups or schools of thought. One paradigm may be dominant until it runs into a difficulty. This is what is happening in medical schools. The prevalence of an organizational structure that undercuts ethics is no longer viable as there exist significant anomalies which cannot be satisfactorily explained within the constructs of the paradigm. Some medical schools survive on competing paradigms but they cannot survive for long as each paradigm answers some but not all questions that contemporary issues force onto the scene and hence, is not capable of asserting absolute authority in the field. Eventually, a paradigm shift will have to occur. It is my contention that it has to occur in the direction of an organizational change towards a culture of ethics.

This is so for a very simple reason: Medical schools and medical doctors have reached a time when they cannot afford to set aside issues pertaining to bioethics. Such issues have become ingrained in the everyday dealings of physicians: patient care, social care, insurance companies, physician-physician relationship, professionalism, research, to mention but a few. If they are to thrive and remain a "profession" a culture of ethics will have to be shaped gradually but firmly. According to Schein, an organizational culture is "a system of shared meaning held by members that distinguishes the organization from other organizations" (1985, p. 32). Thus, he argues, the vision of the organization's founders has a deep impact on the organization's culture and organizational efficacy is possible only when there is harmony between the mission of an organization and its culture. Yet, when the culture itself is becoming a culture where ethics cannot be brushed aside any longer, where physicians are being questioned for their lack of good character and virtuosity so to speak, something ought to happen at the level of the organization or else endeavours for change are bound to fail. Organizational culture is a powerful determinant of the behavior of the people in that organization. It involves what the school professes it does: these are its formal declarations, its practices, its policies and procedures and the way it manages its affairs on a daily basis. This plays a vital role in its success in achieving its mission and objectives, which in schools of medicine includes the making of good and ethical physicians[75]. Thus, an organizational VE is a key aspect of a fully developed ethics of virtue for medicine. Henceforth, the organizational structure of the institution which, to date, remained as it was after the Flexnerian revolution, needs to change if the mission statements of the school in graduating excellent physicians with humane and high ethical standards is to be met. What does such a change involve? To begin with, it involves a change at the level of the mentality of the people who work in the

[75] Cf. chapter 2.

institution or medical school. Bioethics should no longer be perceived as something additional to the practice of medicine, but as something inherent and inseparable from the practice itself. There need to be a written code of ethics of conduct for all students, faculty members, staff and professionals and this code needs to be enforced or else it will remain useless[76]. Compliance standards need to be enforced with responses to offences and assurance that they will not recur. At this point, the nature of awards becomes relevant. A medical school that bestows the "Scientist of the Year" award should also start thinking of bestowing something similar to the "Humanism Award". Everyone working at the medical school should undergo some kind of professional development in ethics training akin to what is required from the Continuing Medical Education Programmes. This must be a requirement on intervals which might not have tremendous effects, but will allow professionals to stay abreast of new developments in medical ethics and keeping them attuned to the fact that medicine and ethics can no longer be separated: that medicine is a moral endeavour. A mechanism of consultation and advice regarding matters pertaining to professionalism and ethics as well as a mechanism for confidential reporting need to be established. Thus, it should be well understood that medicine is a moral enterprise and that being virtuous is not a plus but a minimum requirement from all those who are involved in the care of patients. Most importantly, there should be a commitment on the part of those on the top of the hierarchy and this must be reflected in the school's mission statement as well as its policies and procedures. Finally, it is important to note that the practices of those in prominent positions need to be in line with the new emergent culture of ethics: behavior of superiors and peers as well as formal organizational policies are highly influential. In addition, one has to ensure that there are no contradictions as contradictions in the culture of an organization obstruct change and hinder ethical progress. For example, scrutiny has

[76] See my discussion on p. 55 and p. 71 concerning the interplay between action-based and character-based approaches to ethics.

to be made on white coat ceremonies, committees (for example the role, work and impact of the health ethics committee), required and elective courses, what resources are being allocated and to what? What awards are being given, if at all, and for what? Which courses are better equipped? What kind of pictures/photos decorate the walls of the teaching hospital? The dress code and its policy and other similar issues that are part of the HC and affect the making of the physician-to-be. These are example of minor issues that have a great impact on the HC and carry hidden messages. A discussion of the white coat ceremony will follow as it is considered a major curricular event of growing importance.

To contend that it is enough to have virtuous physicians and that organizations do not matter is, in a way, a psychologically insensitive and morally flawed contention. Thus, when those in power and on the top of the hierarchy overlook their moral responsibilities, the expected result will be some form of demise of the profession as we presented it in terms of its ends.

3.1.4.1 White Coat Ceremonies:

In ancient times and until the 19th century physicians used to wear black which was the color of the formal attire as medical encounters were thought of as formal ones. Symbolically the color black also denoted that medicine was not very capable of helping the patient and medicine used to represent quackery and worthless cures (Shryock, 1947). They were even painted in black like in the famous "The Gross Clinic" by American artist Thomas Eakins which depicts the scene from Jefferson Medical College amphitheatre where Dr. Gross and his assistants (all dressed in black) were operating on a patient. Interestingly, a decade or so later the same painter reveals "The Agnew Clinic" where physicians, assistants and patients are all clothed in white, denoting cleanliness, purity and hygiene. Then the shift took place and resorting to white occurred (*white* comes from the

Latin *candidus* which means candor). The effect of the white coat has been so pervasive that many pediatricians and psychiatrists choose not to wear them in order not to affect their patients. Recent literature talks about the “white coat syndrome”, a condition during which patients become anxious in the presence of a medical practitioner in white manifested by high blood pressure, and gives advice on how to avoid it. The white coat ceremonies are relatively recent happenings in medical schools. They are often construed and viewed as a curricular event. In addition to some of its practical purposes (like protecting physicians from germs and contamination), the white coat stands as a reminder to physicians of their professional duties as set down by Hippocrates who ordains them to lead their lives and practicetheir art in honor and decency. In 1993, and in conformity with the Hippocratic spirit,the Arnold P. Gold Foundation of Columbia University Collegeof Physicians and Surgeons instigated a "White Coat Ceremony"that has been implemented by several medical schools. According to Dr. Gold, a pediatric neurologist, students of medicine were failing to appreciate humanism and professionalism. This led him and his wife to establish the Gold Foundation which supported the organization of the White Coat Ceremony. According to Stern and Papadakis, the white coat ceremony is an event during which students “learn the meaning of the responsibility that comes with wearing a white coat, the expectations for humanism and professionalism” (2006, p. 1794) and to Arnold Gold, the white coat symbolizes the medical profession of 1954, times when

> [t]here were none of the competing values and messages that are prevalent today. Residents and students did what their attendings modeled. Altruism was the rule, and meeting the needs of the patients, whatever the personal cost, was the norm. In effect, both the formal and the hidden curriculum were one in the same, and expectations for success were clearly defined (2006, p, 546).

The white coat ceremony is regarded as a "rite of passage, welcoming the new medical student into the medical profession, albeit as a medical student" (Gillon, 2000, p. 83). During the ceremony, by and large, medical students are welcomed by the school's administration, are lectured about the virtues of the humane physician and the symbolism of the white coat; recite the Hippocratic Oath and promise to practice medicine in compassion and humility and to follow humane and moral standards, all in the presence of family members and guests. They then don their white coats: now recognized as the main symbol of the medical profession. The Gold Foundation explicates the White Coat Ceremony as an experience which "emphasizes the importance of compassionate care for the patient as well as scientific proficiency" (The Arnold Gold Foundation, 2010). Gillon, who started by being skeptical about the ceremony as he himself asserts (2000, p. 84), recommends that all medical schools start introducing a white coat ceremony and argues that he has changed and became a "enthusiastic supporter" of it (2000, 84). With time, the white coat ceremony has become an important tenet of many medical schools and falls within the realm of the HC. It not only teaches the physician about the kind of behavior she owes to her future patients, it tells her that she is in possession of special kinds of power and privileges that are not to be abused, and that she belongs to a distinctive profession. The coat, so to speak, bonds her with all members of the profession wherever they are. Yet, the white coat of the 21st century is no longer the white coat of 1954 as presented by Arnold Gold, nor are white coat ceremonies challenge free: patients often confer status and given power to those wearing the white coat and students easily come to know that: once wearing the white coat, the student does not feel covered by a garment of compassion, rather by one of power, a status he earns even by the mere fact of wearing the coat. This makes the white coat ceremonies a double edged sword[77] and makes one wonder whether

[77] This also explains much of the resistance that medical students had when they were told

this part of the HC is not backfiring and, if it is, what ought one to do about it? Several students are failing to see that it is not the white coat that makes them, but that it is they who make the white coat and that this is related to character development and to upholding certain values that the white coat is supposed to denote. Indeed, Wear argues that the white coat ceremony followed by the wearing of the white coat by students may stand in the way of students developing skills of self reflection that are crucial to the development of virtues that are essential to the practice of medicine (1988). She worries whether the "ceremony, or the white coat itself, is the best vehicle through which to encourage compassionate and humble caregiving" (1998, p. 735) and suggests alternatives or "new rituals" (p. 736) that would allow students to see the perspectives of the underprivileged and unlucky persons. For example, she suggests "first Fridays" during which students would go for community service, set off on scheduled visits to adult day care centers, rape crisis centers, community drug boards, and others. According to Wear, "first Fridays" may become

> the symbol of professional development, a ritualized demonstration of humane medicine, sanctioned by the educators who seek to promote such traits, modeled by caregivers on location, and serving communities whose needs and opinions are often overlooked by the dominant (including the medical) perspectives of our culture" (p. 737).

In his "Deconstructing the white coat" (1989), Branch ponders activities like "first Fridays" and white coat ceremonies. According to him,

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that as students they will be wearing 'short' coats which denote their status of students instead of the regular ones the actual doctors wear.

> White coat ceremonies seem to try to inoculate students against the unsavory effects of the informal curriculum: the lack of compassion, the blurring of ethical boundaries, the treating of patients like objects, and other moral quagmires that probably affect the education of medical students at least as powerfully as the hidden curriculum of symbols does (p. 741).

Branch concludes that white coat ceremonies and "first Fridays" are "inadequate to support the professional moral and ethical development of students" (p. 741). He adds that Wear's proposal is praiseworthy but may lead to cynicism unless its realization is cautiously designed and backed up by suitable construct and mentoring. In 1995, Branch and his colleagues came up with what he calls "an alternative approach"[78] (1989, p. 741) to support the professional development of third year medical students: a "required curriculum of weekly small-group sessions in which students reflected on their ethical and humanistic values throughout the third-year clerkships" (1989, p. 7421). Although this alternative does offer students an opportunity to keep their moral values active during their clerkship years, yet, it remains a fact that the exercise belongs to the realm of the formal curriculum and one can argue that inherent in both proposals, that of Wear and Branch is a tacit worry about the creation of a virtuous physician. The HC and the IC are here to stay and have powerful impacts on students and faculty alike. They lurk within the organizational culture of the institution regardless of whether one wants them, is aware of them, or is attuned to them. Thus, Branch concludes his 'deconstruction' of the white coat by saying: "we should have more white coat ceremonies" (p. 741). Yet, it is my contention that the white coat ceremonies are only a medium: what is significant happens *during* this ceremony. What message is being sent? Who is giving the speech and what does it say?

[78] See Branch et al. "A new educational approach for supporting the professional development of third-year medical students in *Journal of General Internal Medicine*, 1995.

Who is donning the white coat? Does this person have the characteristic of the role model to be emulated? Is the white coat ceremony still-born or will there always be a reminder of it? What is the hidden message conveyed to the physician-to-be: that ethics matters and is an essential component of the physician's life and profession? Or is it that ethics is only a formality and after the ceremony it is business as usual? One way out of this conundrum would be to dwell on the thought of Sandra Gold: "every physician in training should spend a week as a patient' (2006, p. 549). Recounting the narrative of one medical student whose mother died of pancreatic cancer, she quotes him saying:

> I returned to school and slowly caught up, but I was changed. I returned with the perspective of family. I knew what it was like to have a refrigerator full of medicines, to take drugs only to counter the side effects of other drugs, to be powerless. I learned how much our health can affect those around us and how a care provider must often work with an entire family of hopes and fears, and *I came to see, truly and deeply, that the reason for those texts, and those microscopes, are our mothers and wives, our children and neighbors, our colleagues and teachers, our patients*[79](2006, p. 249).

This thought has been recently put to practice at the University of New England when, a medical student, 38 year old Kristen Murphy, learned firsthand what it means to be dependent on others in one's daily chores: she lived in an elderly nursing home as an 85 year old stroke patient as she was studying to become a geriatrician (Zezima, 2009). One might argue that this programme is laudable but not practical as most of the elective courses that medical students take do not exceed four weeks in duration. Yet, one can argue that something shorter, within the same spirit, might become a universal

[79]My emphasis.

requirement. Having every medical student work as a nursing assistant for a week would be a good learning experience for a start. Also, the same idea was introduced in 1991 towards the end of the film *The Doctor* (Haines & Ziskin, 1991). After becoming a patient and having seen what it means to be on the other side of the stethoscope, Dr. Maggie requires that his students all wear hospital gowns, eat hospital food, undergo tests and live the life of an in-patient for a week. Having students undergo these experiences, the white coat ceremony would be more meaningful and more powerful as a curricular event. Students would come to appreciate the elements that make for what it means to be a doctor and what the white coat really stands for. These are encapsulated in the physician-patient relationship.

I have established the importance of the HC and the organizational culture in the prevalent paradigm shift that is inevitably taking place in modern medical education. Yet, one cannot deny the prevalence of an important matter for educators to ponder: How can one measure and assess the content, process, product and outcomes of the hidden curriculum? More will be said about this in chapter 4 when the practical implications of the clandestine curricula in medical schools will be tackled.

3.1.5. The Informal Curriculum

TheIC is often confused with the HC. However, these are two different things. The IC is the way one sees people treating each other, and the way one sees himself being treated. Thus, the IC is part of the social environment the student lives in. According to Gofton and Regehr, the IC "is the process by which a learner's knowledge and skills become situated in the context of daily work. It is not structured but is opportunistic, with appropriate lessons being offered when appropriate learning opportunities arise" (2006, p. 20). It takes

place in the coffee shop, the elevator, the hallway, the wards, etc. In other words, it occurs in the unexpected sites albeit almost continually. Pellegrino and Thomasma argue that "the most effective instruments of character formation are the professionals who teach in medical and law schools and seminaries. But they must be able to *demonstrate*[80] competence and character are inseparable" (1993, p. 158). Indeed, medical students quickly learn the rules of appropriate and efficient behavior by seeing those with influence behaving one way or another (Hilton, 2004). This makes the IC a fecund ground for effective influences on vulnerable and impressionable students who, directly or indirectly, find themselves emulating what they perceive as role models.

3.1.5.1. Role Models in the Informal and Hidden Curricula:

Role models will teach by example, motivate, enthuse and leave a long lasting imprint on the neophyte physician (Ambrozy et al., 1997; Wright, 1996; Wright et al., 1998; Reuler et al., 1994). Wright and colleagues even maintain that teaching the psychosocial aspect of medicine is viewed by students as excellent faculty role modeling. According to them, "being an excellent role model are related to skills thatcan be acquired and to modifiable behavior" (1998, p. 1986) which is quite an Aristotelian perspective to acquiring virtues. Nevertheless, there is no magic recipe that makes one become a good role model. Physicians often discover that they are a role model (either good or bad) to some student. Indeed, negative role models equally play a role in the shaping of the future physician (Mutha et al., 1997). In one prominent university, a third year medical student witnessing an attending physician often charging patients whenever possible (even without seeing them) by asking students to put his name on their charts once reported to his ethics professor that although he disagrees with this behavior he finds it lucrative and an easy

[80]My emphasis.

way to make money. When asked whether he considers doing that in the future, he replied that at times he feels lured into it. This is precisely why good role models should be identified and chosen to spend more time with students. Indeed, some medical schools, like the *University of Chicago Medical Center*, *Indiana Academy of Family Physicians* and the *Baylor College of Medicine* have established the "Physician role model Award", the "Indiana Family Physician of the Year Award", and the "Ben and Margaret Love Foundation Bobby Alford Award for Academic Clinical Professionalism" respectively. Osler believed that mentoring and teaching were inseparable. He came up with a fresh method in medical education which consisted of teaching by example. He was viewed as a role model, an ideal to be emulated and followed by students and generations to come. Yet, the question arises as to whether a role model has to be a heroic or saintly moral exemplar.

In his influential article "Saints and Heroes", Urmson disputes the traditional threefold classification of moral action in terms of the obligatory, the permitted and the prohibited (1958). He argues that there is yet another morally significant class of actions, to the saintly and heroic that falls outside these categories. To illustrate this kind of action, he gives the example of a soldier who throws himself on an exploding hand grenade in order to save the lives of his comrades (p. 202). According to Urmson, this act falls under acts that are good to do but not bad not to do. Such supererogatory acts are morally admirable but are not obligatory and hence, if one fails to do them, one is not blamed or held accountable. Should a physician role model be heroic or saintly in the Urmsonian sense? Indeed, the possibility of there being an urmsonian physician is not farfetched: it is in that sense that one can have a remarkably dedicated, candid and kind doctor who spends a good portion of her time exercising great communication skills comforting her patients and who is willing to walk an extra mile for them, even to show instances of rising above self-

interest and espousing a form of self-effacement[81]. Yet, does that make the physician a good moral exemplar? One can argue that Urmson's example of the soldier sacrificing his life by throwing himself on the grenade to save others is quite un-Aristotelian. Is he not moving away from the mean towards excess? Furthermore, is this all there is to him? A solider? What about his family for example? Does he have no other obligations save to his squad? To his colleagues he is hailed as a hero and a martyr. It might be the same to his family as well. But that does not mean that along with the feeling of pride his family does not have a feeling of betrayal for being left behind. The same applies to the urmsonian physician who delves into excesses. Consider the following case: after an earthquake, an ER physician rotating with the paramedics goes down to the ruins to help the victims. One of them has his hand stuck under the rubble and the building on top is about to crash. He pleads: "please do not amputate my arm, please don't". The physician/surgeon acquiesces although the victim is stuck. Instead, she does her best to save him (waiting for firemen to come and help rescue him) without having to amputate although this took much more time and she put her life and the patient's in danger. Is this heroic? What about her 5 year old girl and the family of the victim- him being the sole bread earner? It all depends on the lens from which one is looking. But life is not a movie one can look at from whichever lens one wants to. It is a whole and the right act has to take the whole into consideration or else "heroic" becomes another word for "excess". Thus, it seems that at its best, the urmsonian vision of saints and heroes can be looked at as a framework within which to operate. The virtuous physician would be one who strikes the mean between the excesses and hence only in that sense, an Aristotelian hero. Virtues and ideals can motivate physicians to go an extra mile. But this extra mile is often blurred. Treating patients with SARS or swine flu

[81] Pellegrino and Thomasma (1993) spoke of self-effacement as a virtue that physicians need to have. This virtue is not much different from the conventional ethics of medicine which bids physicians to put the good of their patients above their own self-interest.

might be seen by many as a duty (society bestows certain privileges on health professionals and expects in return that its sick members be treated) and not a supererogatory act. Although physicians are putting themselves at risk to treat patients (like the example of Dr. Rieux in Camus' *Plague* who commits himself to fight a contagious plague against all odds), or who walk an extra mile (like Florence Nightingale who attends to patients when others have retired to take some rest) some see this risk as a duty while others see it as a heroic act. Indeed, such doctors were hailed as heroes (Hsen & Macer, 2004). Looking at the issue differently, and while acknowledging the existence of saintly and heroic ideals, Beauchamp and Childress argue that many beneficent actions done by healthcare practitioners belong somewhere between "weak obligation" and "beyond obligation" - which is a weak form of supererogation like assisting a visitor lost in the hallways of the hospital (2001, p. 42). Notwithstanding, as stated by Kottow (1990), "[r]ecurring discussions on supererogation appear to reflect the need to see health services in a light more ample and generous than a contract between health providers and patients" (p. 124). Thus, is the physician (or ought the physician to be) someone who seeks to promote beneficence (who promotes the good of the patient), a Levite (bound by clearly stated set of rules), a Samaritan (who seeks to help when she is not obliged to) or an altruist with supererogatory bents? According to Kottow, "common to all descriptions [save the last one] is that they obtain under tolerable cost-benefit conditions, that is, Levitism, Samaritanism and beneficence do not require costs from the agent in any way equivalent, much less in excess of the harm being averted" (2001, p. 125). He concludes that medicine is a "non-magnanimous service" (2001, p. 127): It is unfair and dangerous to require physicians to be supererogatory and it is "better to limit ethical demands on physicians to the feasible and controllable instead of unsettling professional conscience by demanding supererogatory standards that are hard to specify and therefore equally hard to fulfill"

(2001, p. 127). Beauchamp and Childress conclude while giving the example of the obligation to treat patients with HIV stating that

> proposed policies have been controversial, and professional codes and medical association pronouncements have varied extensively. We probably cannot resolve such issues without considering the level of risk that professionals are expected to assume and setting a threshold beyond which the level of risk is so high as to be optional rather than obligatory. (2001, p. 43)

This is why, they add, referring to an article by Georges Annas, (1988) some medical associations require from their physicians to exhibit the virtue of courage and to treat HIV patients while others advise them that treatment is an optional matter and others still stress the virtue of self-effacement and the duty to treat patients. According to the instigators of principlism, such extraordinary persons are often considered as role models and among these role models, the moral hero and saint are the most illustrious (2001, p. 46). They correctly note that one often learns about virtuous behavior from "persons with a limited repertoire of exceptional virtues, such as exceedingly conscientious health professionals" (2001, p. 46). They give the example of John Sassall, the doctor of the mid 1960s who chose to practice medicine in a poverty stricken country and extract four criteria of moral excellence: the agent 1) has a worthy moral ideal, 2) has a motivational structure in the sense that he is disposed by good character to have good motives and desires 3) has an exceptional moral character that allows him to perform supererogatory acts and 4) is a person of integrity (2001, p. 47). These according to the authors, "appear to be sufficient conditions of moral excellence" (2001, p. 47). If one is to argue for virtuous moral exemplars based on this conception, this is not a Sisyphean task. Put in Aristotelian terms, each person should aim to a level as lofty as his potential allows. Some physicians are more prone than others to become moral exemplars, some even moral heroes and saints,

but we cannot, nor should we, require from all physicians to be like that. This is why to argue for heroism and saintliness might make the task altogether difficult. Heroes and saints are inspiring but one cannot demand that a physician be a hero or a saint. One has to choose to become one himself and this would be an added excellence to be saluted.

Notwithstanding, it is my contention that we can, and indeed must, require that physicians be, at least, virtuous. Beauchamp and Childress hold that the person they will "recommend, admire, praise, and hold up as a moral model is the person disposed by character to be generous, caring, compassionate, sympathetic, fair and the like" (p. 29)[82]. Here the importance of character education and the role of virtues become apparent (cf. chapter 2). Once physicians have good character and are virtuous, it is safe to require from them or expect them to play the role of good mentors. In his "On forgetting the difference between right and wrong", Ryle argues that the "notion of moral non education is familiar enough, but the notion of moral miseducation has a smell of absurdity" (1985, p. 159). Physicians often profess to know the good from the bad, the right from the wrong, yet, unfortunately, this is not always reflected in their everyday practice and as such they cannot be good mentors or role models. Ryle maintains that just like it appears inconsistent to say that a person knows the difference between good and bad wine or poetry without caring more for one than the other, it is difficult to imagine a person (a physician for our purposes) who claims to know the difference between good and bad action and caring less for it. Thus, there is an interconnectivity between knowing and caring, between a person (a physician) "knowing that something wrong had been done, but still not disapproving of it or being ashamed of it; of his knowing that something would be the wrong thing for him to do, but still not scrupling to do it" (p. 152). Thus, the question arises as to whether such physicians

[82] Although they do add that character alone is not enough and action must be judged to bring about the wanted results and must abide by the relevant principles and rules (p. 29).

were virtuous to begin with since they did not lack knowledge of right and wrong but lacked that extra something that made them act in the right way. Ryle adds, in quite an Aristotelian flair, that coming to know is also "coming to admire or enjoy" (p. 154)[83].

Role models not only influence the career choices of medical students, they also leave an imprint on the kind of physicians they will ultimately become. The IC is "the overt influence ofthe hallway conversations, dining room and dormitory talk, comments on rounds, and ways of treating persons on the wards to which students are exposed"(Branch, 1998), and hence, it plays a crucial part in forming the professional identity of the future physician, perhaps most importantly, a self image of what kind of professional she will become. The HC functions like an invisible hand and its impact is enormous. As Hafferty and Frank assert,

> [m]edical training is not just about the acquisition of new knowledge and skills, it is about the acquisition of a physician identity and character. Initiates arrive at the gates of medical school with established values. They do not, however, leave medical training with those values intact or unmodified. More to the point, they are not *supposed*[84] to exit from the training process unaltered – at least as far as the culture of medicine is concerned. (1994, p. 865)

In several teaching hospitals, the HC suffers from moral erosion. Students often leave the classroom only to see that what they learned in a medical ethics class about patient autonomy is not being respected. An example would be the OB-GYN attending requesting

[83] However, Ryle does admit that moral deterioration occurs, yet, he argues that what he is denying is that "such deteriorations are to be assimilated to declines in expertness, i.e., to getting rusty" (pp. 150-151).

[84]Italics in original.

that a pelvic exam be done on a sedated woman who has not consented to the examination. Consequently the gap between theory and practice widens and is often filled schizophrenically unless one of two things occurs: 1) students have already identified their *phrominos* or 2) students are armed with moral courage and have the valour to speak up. Thus, in order to reinforce the moral development of students and to ensure that moral erosion is minimized if not eliminated, a number of activities need to be done to support, enhance and/or improve role modeling. As role modeling involves a certain approach in ethical training which exposes trainees to particular attitudes, character traits and behaviors, and, more specifically, to individuals in whom these attitudes and character traits are embodied, various training activities can be seen to enhance this aspect specifically. This might include faculty development programs (conferences, workshops, etc. that deal with issues related to virtues in medicine, mentoring, the hidden curriculum, etc.), peer group discussions (akin to a 'safe space' where peers discuss what they see on the floors, where they share their concerns about good and bad role models and learn from both, ethics rounds (have the clinical ethicist round with the medical team and discuss the ethical sides of the issue when there are any, identify best practices in medicine, connect them to role modeling and use them as teaching moments), grand rounds in practical ethics (tackling issues related to the hidden curriculum, the importance of being a good role model, mentoring, etc. this will instill the feeling that the institution takes these matters seriously, that caring for what it means to be a good physician is part of the culture) , and, perhaps most importantly, exposure to views from the perspectives of patients (which can be done through ethics consults, talking with patients and listening to what they have to say, and using these as learning moments).

When asked what does it feel like to be old? Thirty three year old Mrs. Ramirez replied: painful and frustrating. She partook in a three-hour training program entitled *Extreme Aging* intended to imitate the weakened capacities linked with old age (Leland 2008). Forty-six year old Kim Hansen who also took the course conveyed that the toughest part in the experience was her having to suffer losing people who filled her life: "I gave up my parents first (…) then it was between my husband and my kids. (…) I got very emotional with that" (Leland, 2008). Exercises like this trigger a person's imagination which, in a way, allows one to come close to what the other feels like. They allow one to experience Nussbaum's empathy: an "imaginative reconstruction of the experience of the sufferer" (Nussbaum, 2001). Ethical thinking cannot remain descriptive. It has to move a little further into the realm of moral imagination and, for the student of medicine, try to think what life might be like for the person on the other side of the stethoscope. The same exercise must be done not only with students but with attending physicians who tend to forget what it means to be a patient. Maybe a week's stay in the hospital, wearing patients' clothes, eating patients' food, undergoing tests, etc., might remind them of the other side of the equation. Most importantly, what is also needed is a certain organizational culture that will support ethics teaching and a culture of ethics and professionalism.

One can thus argue that medical education is not something that is simply "offered", rather it is something that is "acquired". And this acquiring takes place at different levels. Some are direct (like formal education and direct tutoring) and others simply happen (like in the case of the hidden or informal curricula) through what I called the "*clandestine curricula*". Yet, in addition to the hidden and the informal curricula, there is also the "phantom curriculum" that one cannot afford to brush aside any longer.

3.1.6. The Phantom Curriculum:

According to Leslie Own Wilson, this type of curriculum is defined as the "messages prevalent in and through exposure to any type of media. These components and messages play a major part in the enculturation of students into the predominant meta-culture, or in acculturating students into narrower or generational subcultures" (Curriculum Index, 2005). An example can very well be the rapidly increasing TV medical drama. A great number of medical students watch medical dramas like House MD, Scrubs, Chicago Hope, or ER. According to Jeffrey Spike, "there should be no shame in admitting that sometimes professional scriptwriters can write a better script than a small team of doctors and ethicists working in isolation at a medical school as if it were a cottage industry" (O'Reilly 2009). The medical drama is becoming a popular genre and has a specific appeal to students of medicine. Such is the case of Fox's medical drama "House MD" whose hero, Dr. House, communicates with diseases instead of patients. The hero of this medical drama is an acerbic physician who practices most of his doctoring on the white-board instead of by the bedside, which, to many of the physicians who teach ethics and belong to the oslerian tradition, is the first infraction in medical practice. In the pilot episode, a notorious, yet memorable, conversation takes place between this tragic hero and his assistant which sets the tempo of the episodes to follow:

> *Foreman*: Isn't treating patients why we became doctors?
>
> *House*: No, treating illnesses is why we become doctors. Treating patients is what makes most doctors miserable. (House MD, Pilot, Episode 101)

An essential feature of the series is the bitter and paradoxical character of the protagonist. House is an antisocial drug addict (he liberally consumes Vicodin for his chronic leg pain) who employs bizarre means of diagnosis and treatment. He habitually risks the lives of patients in an attempt at saving them. This is another questionable behavior that is often debated when considering the ends of medicine. His "epiphanies" are paved with what are

judged immoral resolutions and he is often contrasted with his friend Dr. Wilson, the kind oncologist, who is almost everyone's favorite physician. Put plainly, House's hubris is tragic. Still, the massive fame of the show cannot be dismissed as recent ratings indicate an average of 14 million viewers (Colin, 2009). However, a recent study by Johns Hopkins researchers found that House MD (and another TV drama) was full of ethical breaches and unprofessional misconduct (Czarny, Faden, and Sugarman, 2010). The authors state that

> Dr House is a brilliant clinician who has little regard for social interactions, human relationships or common courtesies. He is disrespectful and harsh to both his coworkers and his patients and will stop at almost nothing in the pursuit of the correct diagnosis and best possible treatment for his patients. The physicians working under him frequently display a high level of dislike for him but at the same time are always seeking his approval. The viewer frequently gets the feeling that Dr House's actions are ethically problematic but ultimately acceptable given his enviable single-minded pursuit of the appropriate diagnosis and treatment (2010, p. 206).

Obviously, what is needed is a neo-Flexnerian revolution that is to redesign the entire medical learning environment. As Gofton and Regeher argue,

> In moving towards the goal of a truly concordant curriculum, it will be important to ensure this is more than a one-time change. To be successful, we will have to design a mechanism to facilitate continual evaluation not only of the formal curriculum, but also of the informal and hidden curricula to ensure that together they transmit a strong message continuing to meet the changing needs of society. In the meantime, we would encourage each individual front line surgical educator to consider and reflect on the significant contribution they are making to the hidden curriculum on a day to day basis." (2006, p. 26)

Watching medical dramas and films that portray physicians as insensitive and opportunistic might have a negative effect as some students my find in this successful physician a role model. The opposite is also true. Films and medical dramas that instigate empathy may make medical students more considerate, understanding of patients, and more altruistic. According to Dobson, this is the "Don Quixote effect" where "imagination overcomes reality" (2005, p. 166). Dobson argues that this effect "could be introduced into the medical curriculum to help medical students develop more compassion, kindness, and caring" (2005, p. 166). Here we witness the fusion of both forms of curricula in the hope of accomplishing one aim, namely, the making of a good physician capable of serving the ends of medicine. In Plato's *Republic*, Socrates contends that "education is not what it is said to be by some, who profess to put knowledge into a soul who does not possess it, as if they could put sight into blind eyes. On the contrary, our own account signifies that the soul of every man does possess the power of learning the truth and the organ to see it with" (1942, p. 227). Henceforth, education here has the job of ensuring that instead of looking in the wrong way, the eyes and minds of students are turned the way they ought to be. Herein lies the role of the medical school when it comes to building the character of the neophyte physician.

3.2. Where Do We Go From Here?

Medical ethics is not a very new field anymore as many schools have already incorporated the discipline in their formal medical curricula. However, the problem still lurks on two levels: the deep-rooted physician who did not have training in medical ethics and who still thinks of the discipline as an intruder deals with it and what ensues from it cautiously. To many such physicians and medical teachers, medicine is a science and medical ethics is something that they *have* to "teach" and it ends there. This is so particularly to physicians

who see ethics as a set of rules to be taught and theories to be memorized and/or understood rather than what ethics ought to be seen when it comes to the making of a physician, namely, a way of behaving inseparable from virtues to be internalized. The second problem lies at the level of the clandestine curricula. Here, a paradigm shift has to take place. In certain institutions it probably has, otherwise we would not have started seeing articles and conferences about the hidden and informal curricula and their impact. Therefore, just like there was a flexnerian revolution towards the basic sciences there needs to be another kind of revolution towards incorporating a kind of VE from within institutions that teach medicine so that the formal and the clandestine curricula speak the same language. Even if one were to try to work around a virtue approach like the one expanded in chapter 2, it remains a fact that virtue requires internal and external conditions for it to flourish. If the external environment impedes the development of virtue, it will not prosper and some virtues might even dissipate and one might see the development of vices (as explained in chapter 2). This is why the organizational structure plays a very important role and cannot be underestimated.

In this chapter, I have raised the question of whether all students who matriculate into medical school should graduate; an issue that will be dealt with in the coming chapter. I also discussed the different kinds of curricula and the role they play in the making of the neophyte physician. The central question that this chapter dealt with was with the role the curricula play in helping students acquire the needed character traits that will allow them to do the right thing even when no one is looking. Another important question remains: What can one do in order to ensure that, practically speaking, students of medicine will do the right thing even when no one is looking and that they will not be a victim of moral schizophrenia? Put differently, what, on the practical level, should be done to create the virtuous physician, the *Pellegrinian* physician? What steps need to be taken in order to

ensure that the mentors will model by word and deed the ethical nature of the medical profession in order to produce the student of medicine who will honor the ends of medicine?

Chapter 4: TOWARDSA POST-FLEXNERIAN REVOLUTION IN MEDICAL EDUCATION

> *"Life is short, the Art is long; the occasion fleeting; experience fallacious, and judgment difficult."* (Hippocrates, 1939, p. 29)

The Palace Thief is a story written by Ethan Canin. It narrates the chronicle of a history teacher at an elite boarding school. The story is a reflection on the vicissitudes of a long affiliation with a spoiled and crooked student and has been turned into a celebrated movie, "The Emperor's Club", directed by Michael Hoffman and starring Kevin Kline. All through, we see the teacher relentlessly trying to mould the character of the student. "However much we stumble, it is a teacher's burden always to hope, that with learning, a boy's character might be changed. And, so, the destiny of a man" we hear the teacher saying (2002). Thus begins the prolonged journey of an attempt at changing the character of a student because, in quite an Aristotelian flair, it is believed that "man's character is his fate" (2002). It is all about human relations. At the end of chapter 3, the following question was asked: "what steps need to be taken in order to ensure that the mentors will model by word and deed the ethical nature of the medical profession in order to produce the student of medicine who will honor the ends of medicine?" in this chapter, I try to answer this question by looking at Flexner's Report, an early attempt at changing medical education and by discussing its five key ideas. I argue that there is a need for a post-flexnerian revolution that will ensure medical schools will graduate the virtuous physician. As this post-flexnerian revolution is not without obstacles, some of the latter are tackled. It will be shown that not everyone who applies to medical school should be allowed in and that even if this happens, not all who matriculate into medical school should be allowed to graduate

and become physicians. Thus, a discussion of admission policies follows. Finally, it will be argued that the virtuous physicians who are already on board have an important task ahead of them that they need to accomplish in order to create a culture that supports professionalism and the making of the good neophyte physician.

If one were to enter Yale School of Medicine, one thing that strikes the eye is the façade of the gigantic granite building which reads: *School of Human Relations*. When he arrived at Yale in 1917, Dr. Milton Winternitz had a dream and a few years later, as he became Dean, he established the school of medicine inscribing it '*School of Human Relations':* He visualized it as a harbor where social scientists would work in collaboration with biological scientists to study human beings as a whole. Unfortunately, this lasted only for a few years (Spiro and Norton, 2003). Medical schools continued to encourage mostly a scientific endeavour. Ever since it was founded, the American Medical Association was uneasy about the fact that physicians had a poor training. Consequently, in 1906, its Council on Medical Education carried out a study of all the medical schools in the nation only to find out that the entire system was in a mess. The only school that was thought to possess the requisites of a good model was Johns Hopkins Medical School (which was based on the German model of a research university). In 1908, the directors of the Carnegie Foundation for the Advancement of Teaching decided to chose a qualified and knowledgeable researcher, Abraham Flexner, to study the nation's medical schools (155 school). His study only confirmed the results of the American Medical Association. The Flexner Report (1910) is now considered as the most significant happening in the history of American and Canadian medical education and it was the driving force that led to modern medical education as we know it. Flexner's Report, as it came to be known, came up with the conclusion that medicine must be taught and practiced on a *scientific basis*. Herein lay the solution to the problem that medical schools faced, yet, herein also resided the root of the

problem that medical schools were to face years to come: they became too narrow minded in their concentration on research and basic sciences to the extent that matters of ethics, professionalism and character became of secondary importance. Nevertheless, Flexner himself was not oblivious to the importance of cultivating the entire physician. Towards the end of the first chapter of his report, he wrote:

> So far we have spoken explicitly of the fundamental sciences only. They furnish, indeed, the essential instrumental basis of medical education. But the instrumental minimum can hardly serve as the permanent professional minimum. It is even instrumentally inadequate. The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different perceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and empathy on a varied and enlarging cultural experience. Such enlargement of the physicians horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility (…) it goes without saying that this type of doctor is first of all an educated man" (1972, p. 26).

Ironically, this important and pertinent passage of the Flexner Report is ignored or forgotten by almost all medical schools, as they seem to concentrate less on teaching and much more on research and clinical duties. Indeed, Flexner rightly pointed out that "the enlargement of the doctor's horizon" (p. 26) is a difficult task. But, along with "insight and empathy" (p. 26) it is necessary for the physician to be the type of doctor the patient needs: to be precise, an "educated man" (p. 26). At this point, the following questions arise: What are the practical steps that a medical school can take in order to ensure that its graduating students will have an enlarged horizon and will be the educated persons Flexner referred to? What guarantees that the students of medicine will graduate having met the mission

and objectives set by the medical school (referred to in chapter one) and will turn out to be the kind of physician who will do the right thing even when no one is looking, physicians who serve the internal ends of medicine? Put differently, what actions can a medical school take to graduate the virtuous or the *Pellegrinian* physician? Briefly, the most effective way is the hiring of faculty members who exhibit the requisite virtues in their own behavior. As Aristotle emphasized, the only effective way to teach virtue is by the example of a respected teacher. In the case of medical students and residents, this must be at the bedside as well as in the clinic, with bioethics and emphasis on the history of eminent clinicians who demonstrated the medical virtues in their lives and practices. These can be viewed as ideals to emulate. In addition, one cannot ignore the importance of the supporting power of an institutional environment that encourages and rewards virtuous behavior. In the end, virtuous behavior on the part of physicians will be a reflection of the moral status of the society within which one practices, its educational goals, religious integrity and cultural value system.

4.1. The Flexnerian Revolution**:**

In the US, and prior to the Flexner Report, mainstream medical schools were owned by eight or ten faculty members (Beck, 2004, p. 2139, Ludmerer, 2010, p. 193). Institutions were basically operated on a profit basis and the success of the establishment was measured based on the amount of profit it generated. There were no clear entrance requirements and the courses that were being taught at these schools were sketchy and shallow in nature. The medical degree consisted of two 16-week series of lectures with the first term being similar to the second. Instruction was basically direct, didactic, based on lectures and textbooks. No laboratory work was done and students relied basically on

memorization. Most importantly, schools were literally “schools”, unaffiliated with universities or hospitals (Ludemerer, 2010).

Abraham Flexner was a private high school director in Louisville and a firm believer in novel methods of medical teaching. His philosophy of teaching emphasized learning by doing. After being asked by the Carnegie Foundation to study the American and Canadian Medical schools he produced a report that consisted of the following key ideas on medical education (Ludemerer, 2010, pp. 194-195):

1. Medicine was basically directed by the laws of general biology
2. Medical colleges must put into effect some entrance requirements
3. The scientific method of thinking was relevant to medicine and henceforth, physicians had to master this method and to apply it in the most cost-effective way
4. In order to learn, students should spend less time in the amphitheaters listening to lectures and more in laboratories and clinics. Thus, emphasizing his philosophy of “learning by doing”
5. Research is very important and physicians should spend a lot of time doing original research. This would also bring thoroughness, enthusiasm and motivation to teaching.

These ideas were important and played a crucial role in the development of medical schools into what they came to be. Yet, one cannot but reflect on these points in light of modern medical schools in an attempt at showing how the views of Flexner should be modified in the light of new developments.

4.1.1. Medicine Was Basically Directed by The Laws of General Biology*:*

While it is true that medicine is basically directed by the laws of general biology, it remains a fact that in addition to being biological and anatomical organisms, patients are consciousnesses that feel, anticipate and predict; they are persons with values and beliefs. It is these characteristics that require a physician to be a physician-healer and not simply a health-care provider or merely a skilled technician. Henceforth, medicine should equally be looked at from the perspective of the humane sciences for it deals with the patient as a whole. It is in that sense that Pellegrino, and in a chapter dedicated to the humane education of the physician, rightly argued that "[m]edicine is the most humane of sciences, the most empiric of arts, and the most scientific of humanities" (1979, p. 17). This veteran physician who practiced for around sixty years in clinical practice continued to maintain that the humanities should be pursued "simultaneously with medicine or even later" (1979, p. 17) as they can "more effectively humanize practice and cultivate the mind of the practitioner" (1979, p. 17).Interestingly enough, years later after he published his Report, Flexner himself felt that medicine has become overwhelmingly scientific. In 1925, he wrote: "Scientific medicine in America–young, vigorous and positivistic- is today sadly deficient in cultural and philosophical background" (1925, p. 18). As Sulmasy noted not long ago, healthcare is a practice based on human relationships and it cannot, and indeed should not, be based on the reductionist view that the ailing person, the patient, is nothing but an assortment of molecular and biochemical reactions to be examined, maneuvered and manipulated. The person is a mixture of the biological, psychological, social and spiritual (Sulmasy, 2006). Dealing with the patient as a disease, as an object or tool, dehumanizes the patient and distorts the physician-patient relationship. This is precisely why at graduation ceremonies (or prior to boarding onto the clinical years), medical students partake in the white coat ceremony and take the Oath, a mark of their profession during

which they pledge to honor their commitment to the care of the patient, compassion, integrity and confidentiality[85].

4.1.2. Medical Colleges Must Put Into Effect Some Entrance Requirements:

This is a very important point that Flexner raised almost a hundred years ago. As a result, entrance requirements were established. Alas, these entrance requirements do not meet the requirements of the 21st century any longer. Pre-medical students, as they are now called, have several academic requirements to fulfill before applying to medical school. These requirements fall basically into a number of courses scattered across the area of the sciences (chemistry, biology, and physics) in addition to a language course and electives. Many "pre-med" students choose their electives solely from the biological sciences which adds to their lack of culture and refinement. However, pre-requisite courses in the history of medicine, medical literature, bioethicscan enrich the horizon of the pre-med student and deepen his sensitivities to matters which, although non-scientific, are very important to his future practice as a physician. Talking about the medical humanities, Howard Spiro, a physician from Yale University School of Medicine argues that "[i]ntroducing these concepts to future physicians should begin before medical school" (Spiro, 2006, p. 997). He continues saying that

> "[s]tudents who identify themselves as "premedical" could have a program less focused on the hard sciences and far more on anthropology, history, and relevant literature. Students who think about the humanities in those impressionable college years should be better able to intertwine real human emotions with their later care of patients" (Spiro, 2006, p. 997)

[85] While oaths might vary among different schools, these are some common tenets that are universally upheld.

Thus, it becomes clear that medical schools should rethink their pre-medical courses and entrance requirements in a way that will shape the entire person who will become the medical practitioner of the future.

4.1.3. Learning By Doing*:*

This philosophy currently pervades all medical schools of the 21st century. Although students are required to take courses in the basic sciences, they ultimately have to go the laboratories and learn by the bedside, a phenomenon that came to be known as Oslerian medicine. Unfortunately, bedside medicine soon became bedside teaching and patients often were turned into teaching tools whose rights were abused for the purposes of teaching. While this might not be true of all patients, it is definitely true of at least some. It is my contention that 'using' (where by 'using' I mean any involvement of patients for teaching purposes where their free, explicit, valid consent for that particular purpose has not been provided) one patient as a tool for the sake of teaching and allowing his rights to be encroached upon (like the case of the patient who underwent a forceps delivery presented in chapter one) undermines the profession of medicine and what it stands for. Patients might acquiesce to be learned from and this is generally the case in all teaching hospitals, notwithstanding, this has to emanate from a consent (either tacit or explicit) and with this consent ensue a number of duties and obligations that the student of medicine and the attending physician have to respect. Any abuse of the status of the patient is an abuse of the social contract[86] that the profession of medicine has made with society. Henceforth,

[86] Society gave physicians social standing, respect, autonomy in practice, the advantage of self-regulation, as well as financial rewards all based on the prospect that physicians would be proficient, skilled, altruistic, ethical, and would deal with the health care needs of patients and of society (Cruess and Cruess, 1997, pp. 941-952) . This understanding constitutes the quintessence of the social contract.

while the philosophy of learning by doing might be right, the way it is carried away ought to be revised according to certain policies and procedures that safeguard the profession from serious ethical breaches. Policies and practices that do not uphold ethics and that endanger patient care (for example that do not take into consideration the autonomy of the patient by ignoring the importance of informed consent) should be altered. Patients are not tools to be used as a means to an end; they ought to be partners in teaching.

4.1.4. Engaging in Original Research*:*

Modern day medical schools are known as 'research universities'. Most of them follow the adages "publish or perish" and "patent and prosper". While Flexner was hoping that research would pour into teaching and be an added value that would enhance the thrill of the teacher, modern day medical schools have revealed that research has taken away the time from teaching. It is common knowledge now that medical schools rarely promote teachers for teaching well, for being creative or even for being compassionate and caring for the sick. The reputation and standing of faculty members rests on the number of NIH grants they get and publications they issue. Physicians worried about promotion requirements hardly give enough time to teaching – (which they often view as a burden they have to do unwillingly), let alone teaching well and even less time to seeing patients. Thus, research became a double-edged sword. While it was thought that distinction in teaching, research and clinical skills were the marks of excellence; it became clear that because of the emphasis on research, teaching and clinical skills have suffered. In addition, the mounting turmoil of the healthcare environment over the last few decades led to the development of conditions that were unfavorable to medical education as Flexner

himself was aware of and, in the US in general as well as in Lebanon "[c]linical teachers have been under intensifying pressure to increase their clinical production - that is, to generate revenues by providing care for paying patients. As a result, they have less time for teaching" (Cooke et.al., 2006, p. 1340). This has caused faculty to develop an attitude towards their professional life and students even hear their teachers speak and worry more about the market and the financial revenues than about curing the sick and relief of suffering (Cooke et al., 2006, p. 1340). Consequently,

> we arrive at our current predicament: medical students and residents are often taught clinical medicine either by faculty who spend very limited time seeing patients and honing their clinical skills (and who regard the practice of medicine as a secondary activity in their careers) or by teachers who have little familiarity with modern biomedical science (and who see few, if any, academic rewards in leaving their busy practice to teach). In either case, many clinical teachers no longer exemplify Flexner's model of the clinician-investigator (Cooke et.al,. 2006, p. 1340).

Moreover, some physicians eager to have their names appear on publications for promotion reasons forget the rules of authorship and research ethics and go about it the wrong way. For example, they use medical students who do the work on their behalf and end up putting their own name on the research instead of that of the student. Such events are not anecdotal but happen quite often. The ends seem to justify the means and as a result, Flexner's educated physician seems to have lost her horizon in the process.

Thus, one can conclude that Flexner did his best to revolutionize medical education and to transform it into a full-fledged education that enhances critical thinking and intellectual skill and vigor. Yet, what is lacking in today's post-flexnerian medical education is a moral

dimension that will ensure that the student of medicine will acquire the necessary character traits and skills that will make him a good virtuous physician willing to put the interests[87] of her patients before her own[88].

4.2. Medical Education and the Physician of the 21st Century**:**

One of the most important issues that one has to contemplate before looking at the role of education in the making of the 21st century physician is the true purpose of medical education. Back in 1956, the *British Medical Journal* published an article in which doctor Pickering said: "The proposition that the purpose of medical education is to turn out properly trained doctors would probably receive general assent. There is, however, dissent about what constitutes a proper training and yet more about what kind of doctor should be trained" (Pickering, 1956, p. 4985). Perhaps the same still holds true today. In 1800, Dr. Newman wrote that the aim of a physician's education was to yield "a cultured and highly educated gentleman with, quite secondarily, an adequate knowledge of medicine." (Rao, 1961, p. 1234). When asked about the reason they join medical school, many students suggest that one of the main reasons they join is related to their belief that medicine guarantees a certain decent lifestyle that they would like to achieve. Unfortunately, these are the students who ultimately become physicians, yet, this is joining the medical

[87] Indeed, the medical profession today, more than ever before, faces a dilemma in that it finds itself having to choose between two opposing forces (and thus two separate moral spheres): one which stresses the predominance of the profession's responsibility to the sick and the other the predominance of self-interest and the marketplace.

[88] One can argue that it does not make a difference if not all schools require the taking of an oath for the Oath itself is not a guarantee that medical students and physicians will act ethically and be virtuous. My criticism is that there need to be some other form of training (formal, informal and hidden) that will help nurture character traits that will allow for the making of a good physician. On another note, I am not saying that character *alone* is enough. VE will always need the help of some rules for human nature is week.

profession for the wrong reasons and this has almost always been the case[89]. Back in 1925, Dr. Bass argued that

> Those who are engaged in other pursuits in life are likely to think, upon superficial consideration, that the purpose of medical education is to provide a gainful occupation for those who enter the medical profession. No such purpose could justify it. In the first place, considering the cost of education, the effort put forth, the arduous duties performed, and the sacrifices made, medicine is anything but a money-making occupation. In the second place, personal gain by capitalizing the suffering and distress of our fellow man does not require the knowledge of the facts that are learned thorough medical education. In fact, those who are so unscrupulous and so heartless as to do this, succeed through ignorance of, or disregard for, the facts taught by medical education rather than by knowing and applying them (Bass, 1925, p. 13).

A little further, Bass adds that medical education "equips the physician with needed knowledge and aids him to render health service to those whom he serves" (Bass, 1925, p. 13). He concludes by saying that "the purpose of medical education is the promotion of health, the happiness, the welfare and longevity[90] of mankind" (Bass, 1925, p. 14). Put simply, the purpose of medical education is to inculcate the student of medicine to serve the ends of medicine. Henceforth, if education does not meet this goal, then something is wrong and has to be revisited. It is my contention that the medical education of 21st century is no longer meeting its goal in serving the ends of medicine which is to say healing the

[89] Students join for the wrong reasons because they have the external ends of medicine in mind not its internal ends. Two points are relevant here: 1.The external ends of medicine are not part of its essence; 2.If everyone did so (or if it has so far been the case for some time by most students) it does not make it right.

[90] Although with the development of medical technology, it is no longer longevity alone that matters, but issues pertaining to quality of life as well.

patient and restoring his health when this is possible and when it is not possible, this activity has to be directed to relieving his pain. This is not to say that the learning objectives that meet the ends of medicine are not available. For example, the Association of American Colleges published a report in 1998 in which it stated that

> The goal of medical education is to produce physicians who are prepared to serve the fundamental purposes of medicine. To this end, physicians must possess the attributes that are necessary to meet their individual and collective responsibilities to society. If medical education is to serve the goal of medicine, medical educators must develop learning objectives for medical education programs that reflect an understanding of those attributes (Association of American Medical Colleges, 1998, p. 3)

The AAMC claim that these attributes included the possession of altruism, knowledge and skill. Under altruism, the Association of American Colleges stipulated that before they graduate, medical students should demonstrate the following:

- Knowledge of the theories and principles that govern ethical decision making, and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life and those that arise from the rapid expansion of knowledge of genetics
- Compassionate treatment of patients, and respect for their privacy and dignity
- Honesty and integrity in all interactions with patients' families, colleagues, and others with whom physicians must interact in their professional lives

- An understanding of, and respect for, the roles of other health care professionals, and of the need to collaborate with others in caring for individual patients and in promoting the health of defined populations
- A commitment to advocate at all times the interests of one's patients over one's own interests
- An understanding of the threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for the practice of medicine
- The capacity to recognize and accept limitations in one's knowledge and clinical skills, and a commitment to continuously improve one's knowledge and ability (Association of American Medical Colleges, 1998, pp. 4-5).

This was more than a decade ago. But were these objectives met? The general dissatisfaction with the ethical traits of physicians testifies to the fact that these objectives were not met and this is so not only in American medical schools but world-wide, hence, it was argued that a "physician's lack of humanity is a general complaint in public surveys. The physician-patient relationship is often viewed by the public as being reduced to a *business relationship*[91], where the patient feels that she is merely a 'client' and the physician simply a health-care 'practitioner' instead of 'care giver' and 'healer'" (Arawi, 2010, p. 23). Recalling an incident that happened while attending a conference in London to discuss the "medical humanities", Campo recounts the story of a medical student inquiring about what the medical humanities are and how he wanted to bring up a definition,

[91]Italics in original.

> knowing intuitively that the way medicine is now taught and practiced is simply *wrong*[92], that the humane is being supplanted by unfeeling science and uncaring economics—the incalculable distress I feel when I hear an intern refer to her patient as "the breast cancer in room 718," the ephemeral sadness in cutting short a visit before we can delve into my patient's grief at the loss of her husband because I have three others waiting (Campo, 2005, p. 1009).

Physicians themselves are becoming aware that "the way medicine is now taught and practiced is simply *wrong*" (Campo, 2005, p. 1009). Put differently, medical education is practiced in such a way that students of medicine are not attuned with the ends of medicine as they ought to be. Rather, they are more prone to see the external ends of medicine rather than its internal ends and this is leading to some form of moral and professional dissonance. That being said, it is my contention that there is a need for a new post-flexnerian revolution that will ensure that medical schools will end up graduating the physicians they claim they want to graduate (as stated in their mission and objectives referred to in chapter one). This new revolution will have to be at the levels of the formal, informal and hidden curricula and its aim should be the making not only of a physician, but of the "virtuous physician" or the "Pellegrinian physician". It will be an education that will transmit knowledge, pass on skills and instill the values of the profession. Having said that, the first matter of concern is the student matriculating into medical school. Should any student with the right academic record become a physician? Put differently, should all

[92]Italics in original.

students who apply to medical schools be accepted or should medical schools have certain criteria[93], other than scientific requirements, for accepting new matriculants?

4.2.1. Admission Policies*:*

Quantitative criteria are the basis of most selection processes used in medical schools. With time, they have gained validity and reliability (Davidson and Lewis, 1997, pp. 1153-8). Yet, this is not to say that academic criteria (GPAs and MCATs) are the only requisite measures for entry into medical schools. In the year 2000, the Lancet reported the story of a physician by the name of Dr. Michael Swango who was "wanted in Zimbabwe for the murder of five patients and attempted murder of three other individuals" (McCarthy, 2000, pp. 1010). According to the *Lancet*, Swango poisoned his patients for the "thrill and power" that he felt while looking at them as they died (McCarthy, 2000, pp. 1010). The sad and perhaps careless part of the story is that Swango's irresponsible and psychotic behavior dated back to his days in medical school and continued through his residency: As a medical student at Southern Illinois University, he became known for his bizarre behavior and for losing patients under his care. He was inappropriately allowed to graduate and to practice medicine in a morally dubious manner (Steward, 1999). The question that arises at this point is the following: Should the Swangos of the world be allowed to

[93] Ensuring that appropriate criteria are applied is not an easy task. There will have to be a taskforce dedicated for this. Whatever tools are designed will have to be piloted and tested and validated. Criteria will have to take into consideration the nature of the medical profession, the internal ends of medicine and the nature of physicians one wants to graduate in such a way as to measure those criteria that are essential for the practice of medicine (screening for character traits consistent with certain personality disorders). Traits that have little consequence for the students' interactions with patients and peers should not be a matter of concern. For example, in a society where homosexuals are not 'tolerated', homosexuality must not be a matter of concern as far as admission criteria are concerned. The purpose is not to have a society of *similars* (this might even backfire).

matriculate into medical school to begin with? And assuming they did matriculate, should they be allowed to continue their studies and hence should the medical school be justified in turning a blind eye to several alarming signs of their immoral or amoral behavior? Swango might be an extreme case, but there were cases of less severe infringement. In the same year the *Lancet* published the Swango story, the *British Medical Journal* published an editorial by a medical student attending the Royal Free and University College London Medical School. The student narrated an episode where a colleague of hers overtly cheated on an examination and was caught on the scene. Although the 'cheater' was asked to stand before a disciplinary committee and was reprimanded, she was nonetheless allowed to graduate (Smith, 2000, p. 398). The editorial condemned the decision of the medical school, describing it as a malfunction of their social responsibility. As a result, the *British Medical Journal* was inundated with mail, some supporting their opinion and others not. Point being, the issue stirred public opinion as although it was a matter of serious importance and impact, yet, it was not properly dealt with by the medical school itself.

Osler affirmed that "in the physician or surgeon no quality takes rank with imperturbability… coolness and presence of mind under all circumstances" (Osler, 1932, pp. 3-4). Such important qualities are often left unmeasured by entrance examinations or admission tests that students are asked to take prior to matriculation into medical schools. Consequently, the General Professional Education of the Physician and College Preparation for Medicine (GPEP) report made a case for the use of assessment of qualitative variables when medical students are evaluated prior to entering medical school (Muller, 1984, p. 1- 208). Qualitative variables are defined as attributes of a person's "character, personality, personal or social history that contribute to success as a medical student and physician" (McGaghie, 1990, p, 145). McGaghie rightly argues that such

variables are important for professional competence and hence should be assessed and evaluated among potential medical students, yet, it is not the case (McGaghie, 1990, p. 145). Some authors have argued that "tests of moral reasoning are inappropriate for use as selection instruments" and contended that it would be more valuable to consider individual differences in "moral orientation" (Bore, et al., 2005, pp. 266-277).

In 1980, Rudolph Weingartner suggested ten categories in the list of qualitative variables to screen medical students (Weingartner, 1980, pp.922-927). The list consisted of the following attributes: character and integrity, breadth of knowledge, evidence of leadership, geographic preferences, genre, race and religious preference, work habits and motivation of study, personal tendency toward service, altruism, and personal effectiveness. For example, the American University of Beirut Medical Center relies on the scores of the MCAT and the undergraduate GPA in core premedical courses to decide who gets into medical school and who does not. Yet, it recently introduced a structured and semi-structured medical interviews system during which each applicant is met with for around an hour with two interviewers[94] who asked him questions and gave him ethical scenarios which represented moral dilemmas. The student was expected to listen to these scenarios read to him by the interviewer and to comment on them focusing on the following: ethics, altruism, team work, their sense of individual vs. societal rights, as well as their appreciation of respect and autonomy. Interviewers were asked to rate the responses of the candidate without discussing them amongst themselves. Although Inter-rater reliability checks revealed high correlation between the scores of the interviewers, to date, these interviews have not played a role in the acceptance of the applicant but the medical school

[94] It is important to ensure that those who are conducting the interviews are themselves professional interviewers, good role models and ethical people. Interviewing is an important function and much more than one or two interviewers should be interviewing the candidate and these should be compensated for performing this essential function.

feels that it should be the case as character is as important as knowledge. The main hindrance faced is the validity of the interviews in assessing the character of the interviewee. After all, the scientific validity of one hour interview is thought to be weak or not quite valid and has to be assessed.

Clearly, admission committees ought to incorporate a mechanism through which qualitative variables are assessed prior to admission to medical school as this has a bearing on the kind of physician the student of medicine will end up being. As much as training in the virtues can help mould the character of a neophyte, one cannot ignore the fact some students are simply not made for medical school in the ethical sense of the word: put differently, some students are not fit by character to become physicians. As stated in chapter two, Aristotle maintained that nothing can form a habit opposingto its nature. He also stated that "it makes no small difference, then, whether we form habits of one kind or of another from our very youth; it makes a very great difference, or rather *all*[95] the difference" (1947, p. 332). Years later, Pellegrino echoed this in a different way stating that, "[c]haracter formation cannot be evaded by medical educators. Students enter medical school with their characters partly formed" (Pellegrino, 2002B, p. 383). Thus, faculty members in medical schools not only have the responsibility to help neophyte physicians learn good habits of character but they also have to help them get rid of bad ones. As Aristotle himself states, one is able to become good by unlearning bad habits and learning good ones. The same holds of the virtues. If one is habituated to deal unjustly or high-handedly with a patient, one can unlearn this habit by treating the patient justly and modestly over and over again. This requires the help and tutelage of the right professional role model who is willing to patiently and relentlessly observe and guide the student. But this also requires that the student is already someone who has in himself the right

[95]Italics in original.

dispositions to become good. It is not an easy task, but it is not an impossible one either. The moral development of the student is a crucial task and enough time should be allocated for it starting from matriculation all through to graduation. The moral and character development of the student can be assessed by the 'student professionalism committee' (explained below) that will develop a checklist and will follow the student's moral and character development all through his years of medical training until he acquires excellences of character and practical knowledge (the capacity to see what one ought to do or feel in a certain situation). This will become even more apparent when the student starts enjoying doing the right thing since the truly virtuous person takes pleasure in his virtuous activity.

Thus, some characters are made to go into medical school and others are not. These characters must be sifted at the beginning, prior to matriculation. Once into medical school, the training in the virtues discussed in chapter two will be more effective and will yield better results. Here comes the role of an admission's committee which should consist not only of physicians but should also have at least one bioethicist, philosopher and psychologist. The bioethicist is the person versed in clinical ethics and can help in the framing of ethical scenarios and questions suitable for the clinical setting. The philosopher will also play an important role in assessing the validity of these questions, scenarios, and their internal consistency and will help drafting questions in such a way as to frame scenarios that will reveal internal inconsistency within the answers of the applicant. The role of the psychologist cannot be overestimated. She not only should serve on the committee but must also be present during the interviews, in an attempt at trying to assess the character and personality of the applicant. Thus, psychological tests should be introduced to assess the psychological reaction of the candidate under pressure and in certain situations of stress; questions that reveal certain delicate traits of character should

be asked so that such traits are revealed. One can also argue that the candidate's school record from the middle and secondary school years should also accompany his application[96]. The importance of this lies in the fact that the emotional growth and the ambitions of the student can be detected through the comments of their teachers/advisors and peer reviews. A student who has been reported as developing into an aggressive, selfish person cannot be a good candidate. Alternatively, a student who has been reported to be caring, understanding, and a good listener can be a good applicant. One shortcoming of this would be the reliability of school reports. Hence for this to be implemented, a revolution has to be implemented at the level of schools as well. Yet, one can safely argue that, in general, students of medicine ought not to be selected purely based on their intellectual abilities and that there need to be some form of assessment of their character traits. There were several attempts to do that and one such attempt was trying to assess the emotional quotient (EQ) of the student in addition to his Intellectual Quotient (IQ) (Borges et al., 2009, pp. 565-572). Emotional intelligence was first defined near the beginning of the 1990s by Salvoy and Meyers as "a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them, and to use this information to guide one's thinking and actions." (Mayer and Salovey, 1993, pp. 432-442). According to Romanelli et al.,

> All health care professions are rooted in a need to establish therapeutic relationships with patients. Within these relationships, the professional must respond to both the technical aspects of disease as well as associated emotional aspects. (…) If this theory holds true and with various managed care and other environmental constraints being placed upon practitioners from all health fields, it

[96] Needless to say that there are many cases where letters of recommendation are written in an ad hoc manner and do not truly reflect the character or standing of the applicant. Thus the question: should all professors be allowed to write a letter of recommendation? Should any letter of recommendation be considered? What should the relevant criteria be?

> may become critical for students in the health professions to have emotional intelligence to provide high-quality patient care (Romanelli et al., 2006, p. 5)

As the heart of medicine is the physician-patient relationship, being able to interpret or understand and handle emotions is a very important skill that prospective medical students need to have. This skill can be a good guide to thinking and acting. Carrothers et al. (2000, pp. 456-463) were the first researchers to apply this theory to medical school admission processes and henceforth to develop a mechanism to measure emotional intelligence to be used in the selection of students applying to medical school. The result of their study revealed that

> the EI instrument identifies applicants who are oriented toward the social sciences and humanities and who have those qualities of emotional intelligence— maturity, compassion, morality, sociability, and calm disposition— that indicate competency in personal and interpersonal skills (Carrothers et al., 2000, p. 461).

Notwithstanding, some researchers and scholars still doubt the validity and relevance of the introduction of an assessment of emotional intelligence into medical school entrance examinations. Wagner for example thinks that "such inclusion may be premature" (Wagner, 2006, p. 477). Still, according to a commentary writing in the *Journal of the American Medical Association*, training in emotional intelligence can assist medical residents and fellows develop into more sensitive healthcare practitioners vis-à-vis their patients (Grewal et al., 2008, pp. 1200-1202). Thus, it's worth investing more time and effort in deciding the role emotional intelligence plays in the physician-patient relationship and if the correlations are found to be positive, assessing medical school applicants on this basis should be highly recommended.

Although one might argue that what follows is just a speculation, yet, as an applicant to medical school, Swango would most probably not have passed the interviews or the tests

suggested by Carrothers et al. If interviewers were careful enough, if psychologists were attuned enough, an alarm would have rung and such students would not have had the chance to graduate and to do the harm they did. Another issue that was raised at the beginning of this section was whether matriculated students should be allowed to graduate no matter what. Several authors have asserted that assessment of readiness for medical education should not be restricted to academic qualification (Puschmann, 1966). Rather, character qualifications should also be taken into consideration. Indeed, in the early 1970s, the Association of American Medical Colleges started to introduce changes in the methods of assessing applicants for medical schools. The purpose was to include assessment of character traits in the MCAT. However, the project was soon abandoned[97] (McGaghie, 2002, pp. 1085-1090).

4.2.2. Not Everyone Should Graduate**:**

Graduation rate at medical schools has always been very high. For example, at the American University of Beirut Faculty of Medicine, it has always exceeded 96 - 97 %. The remaining 3-4 % includes students who fail, withdraw and/or students who decide to pursue an MD-PhD programme outside the institution and abroad. No student was asked to leave the university because of ethical reasons or character issues. Yet, cheating and ethical infractions such as breaking of confidentiality, signing informed consent forms on behalf of attending physicians, and participating in dubious research do occur. Papadakis and colleagues published a number of studies indicating a close correlation between problems with professionalism among undergraduates and residents with subsequent reporting to

[97] It is ambiguous precisely why they let go of the humanities sections (roughly encompassing knowledge of current events, sociology, character traits, etc.). Probably that they thought the interview process and essays could offer a better measure of such matters.

medical boards (Papadakis etal., 2001, pp. 1100-1106; Papadakis et al, 2004, pp. 244-249; Papadakis et al, 2005, pp. 2673-2682; Papadakis et al., 2008; pp. 869-876). Thus the question: should all students who matriculate be allowed to graduate simply because they meet graduation criteria in terms of courses, or should moral requirements play a role? Put differently, should everyone who enters medical school be allowed to become a physician? Pellegrino rightly pointed out that

> [t]he prime task of medical schools is to prepare new physicians with the skills and knowledge that would make them safe and competent practitioners after graduation. This in a significant degree implies some conscious shaping of the character of medical students so that they will exhibit, then as students, and later as practitioners, those virtues entailed by the idea of a profession (Pellegrino, 2002 B, p. 384)

It is my contention that medical schools should not educate students only in skill and technical competence but equally, and importantly, they should also educate the students in character. A recent study revealed that the public believes that the majority of physicians are quite apt in skill and technical expertise but lack ethics and interpersonal skills (Arawi, 2010, pp. 22-29). This change in graduation requirements implies setting standards below which students of medicine should not fall and if they do, certain actions ought to be taken to correct this. Henceforth, students who exhibit character traits that do not suit the profession of medicine, students who were admitted to the school of medicine "by mistake" and who are not growing in the virtues and are rather far from the needed virtues of medical professionalism, should not be allowed to stay even if their scores in the medical sciences are quite high. These students, it might be argued, might eventually grow into wrong exemplars like Dr. Swango above, the Nazi physician or Dr. Mengele. This implies a new change in the graduation criteria and a commitment on behalf of the medical

school's admission and graduation committee to set new standards. For example, during their four years of medical school, and before they graduate with an MD degree, each student must be closely followed up by an advisor who works with a core committee (let us call this the 'student professionalism committee') and who evaluates the student's ethics for example twice every year. The core committee will consist of the advisor and of some members from the medical faculty (known for their character and honesty)[98] who will follow up on the students' development during the year. Students whose ethics and character are found to be dubious or wanting should be asked to leave medical school even if their grades in the curriculum subjects are up to level[99]. Matriculation should not be a guarantee of graduation as is the case in many medical schools. After all, medical schools will not be asking for anything more than what is already stated in *Harrison's Principles of Internal Medicine*:

> No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering, he needs technical skill, scientific knowledge, and human understanding. He who uses these with courage, with humility, and with wisdom will provide a unique service for his fellow man and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less (Harrison et al., 1950, p. 1).

Harrison and colleagues were in a way reiterating Hippocrates' claim that the building of character is a lifetime undertaking. They also suggested that the development of character

[98] How to assess these character traits and other important ones in faculty members is an issue well worth studying.
[99] This will not be easy to do, however, many policies started out being difficult to endorse but then they became regular policies.

forms an important purpose that education has to aim for. In quite an Aristotelian fashion, we sense that this physician who ends up having built an "edifice of character within her" will be happy. Thus, the important role of education in helping shape the character of the neophyte student of medicine to help him grow into the good and happy physician society entrusts itself to.

4.2.3. The Curriculum and the Professional Physician**:**

A lot of articles have been written lately about the deprofessionalization of medicine (Reed and Evans, 1987, pp. 3279-3282; Wynia et al., 1999, pp. 1612-1616; Reynolds, 1994, pp.609-614), a phenomenon which denotes the loss of the special characteristics often associated with the traditional physician like commitment to competence, service, and altruism. Consequently, teaching professionalism has recently become an important issue in most medical schools. Indeed the term 'professionalism' has become the mantra that reverberates in contemporary medical schools. Yet, this is not what this section is about. For it is my contention that teaching professionalism in a formal setting will still be prey to the several shortcomings formal courses in bioethics have faced (discussed in chapter three). Rather, what is needed is a 'culture of professionalism' that will ensure that medical professionalism (and the virtues that come with it) will become second nature in the new physician. Thus, another paradigm shift will have to happen and another mini-revolution within the medical school will have to occur smoothly but firmly. Thus, since a culture of professionalism in medical school ought to be established if one wants to graduate the good virtuous physician, the question becomes: how can the curriculum of medical schools

enhance professionalism among future physicians? This will have to be done through the three forms of curricula: the formal, the informal and the hidden[100].

4.2.4. Medical Curricula, Medical Professionalism, and the Making of the Virtuous Physician:

In 2000, Swick attempted to give a normative definition to the term professionalism and began by saying that "the concept of medical professionalism must account for the nature of the medical profession and must be grounded in what physicians actually do and how they act, individually and collectively" (Swick, 2000, p. 614). He thus defined medical professionalism as consisting "of those behaviors by which we—as physicians—demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients' and the public's good" (Swick, 2000, p. 614). According to Swick, the term encompasses nine[101] normative behaviours, predominantly humanistic traits such as altruism and honesty, integrity and compassion, and he concludes by saying that "[s]erious negative consequences will ensue if physicians cease to exemplify the behaviors that constitute medical professionalism" (Swick, 2000, p. 616). In 2002, the American College of Physicians published the Charter of Medical Professionalism in *The Lancet* (pp. 520-522). Ever since the Charter was released, medical

[100] I will not discuss the phantom curriculum here because this is an area over which medical schools do not have direct control.

[101] The nine normative behaviours proposed by Swick are: 1) "physicians subordinate their own interests to the interests of others"; 2) "Physicians adhere to high ethical and moral standards"; 3) "Physicians respond to societal needs, and their behaviors reflect a social contract with the communities served"; 4) "Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness"; 5) "Physicians exercise accountability for themselves and for their colleagues"; 6) "Physicians demonstrate a continuing commitment to excellence"; 7) "Physicians exhibit a commitment to scholarship and to advancing their field"; 8) "Physicians deal with high levels of complexity and uncertainty"; and 9) "Physicians reflect upon their actions and decisions" (Swick, 2000, p. 614-615).

schools have grown more aware of it and started using it to teach medical professionalism and the importance of holding on to a set of professional values that are appropriate to the profession of medicine. These professional values are very much linked to the virtues referred to in chapter two. Thus, the virtues of medical professionalism were commonly agreed upon to be those expounded by Pellegrino, namely, fidelity to trust, benevolence, compassion, intellectual honesty, courage and truthfulness (Pellegrino, 2002 B, pp. 378-384). The question then arises: how should medical schools help their students acquire the virtues of medical professionalism? To begin with, one should concede the fact that medical professionalism and the virtues that come with it are not taught in one course and that we should not expect that one course (or two or even more) will make students the virtuous professionals we expect them to be. Rather, medical professionalism and its virtues are acquired through the many years of medical training: it is a lifelong project and as Hippocrates noted, "the Art is long; the occasion fleeting; experience fallacious, and judgement difficult." (Hippocrates, 1939, p. 29) There are times when students will be lured by the negative situations they face (e.g. conflict of interest, bad role models and various temptations that they face along the way). Yet, in a healthy and moral medical environment, these forces of erosion can be turned into good teaching lessons that strengthen the virtues instead of weaken them.

There are several publications that help teach medical professionals teach medical students about medical professionalism. Notwithstanding, it is not the literature that teaches, rather the teachers themselves and the experience that the students go through. Brainard and colleagues argue that "the chief barrier to medical professionalism education is unprofessional conduct by medical educators, which is protected by an established hierarchy of academic authority" (Brainard and Brislen, 2007, p. 1010). They wrote their

article in order to share their experience as students learning about medical professionalism. The article reveals that in many medical schools in the US, professional virtues are absent and thus teaching medical professionalism and its virtues becomes an exercise in futility. This highlights the importance of creating a culture that supports professionalism and its virtues first among the attending physicians and the educators themselves and then among students. When unprofessional conduct (like abuse of power, using the patient as a tool, practicing medicine as a business) is protected by an "established hierarchy of authority" (Brainard and Brislen, 2007, p. 1010), the virtues of professionalism will neither be learned nor will they flourish. Rather, the opposite will take place and cynicism will increase. At this point, one has to think of one of two things: either only the virtuous and professional physicians ought to be given the task of mentoring[102] and teaching students (which is exigent because these physicians will have to exist and be enough in number to begin with)[103], or one has to start thinking of creating a generation of first physicians[104] who possess these virtues and are Pellegrinian to begin with. Both options are difficult. In addition, these physicians will have to be placed in positions of power and will have to be equipped with moral courage. They will have to be virtuous, possessors of phronesis and a strong will to fight a system that has been corrupt for many years. They will have to work on creating an environment that will reduce student abuse and insult, will protect the whistle-blowers by means of a set of policies and procedures, and will create a zero-tolerance policy for physicians who are teachers yet who exhibit

[102] In Homer's epic, Odysseus went to fight in the Trojan War and entrusted the care of his son Telemachus to Mentor. The latter served as Telemachus' teacher and advisor helping him develop personal, social and civic skills that helped him gain a good place in society: it was the character of the entire person in question.

[103] Also a mechanism of screening and finding these physicians will have to be put in place, piloted and assessed.

[104] An interesting question that arises at this point is *how to generate the first generation of physicians?*

unprofessional behavior. In other words, first on their list will have to be the hidden and informal curricula of the medical school. These Pellegrinian physicians (à la philosopher-king but who should also avail themselves to the advice of other members of the institution) will have a lot on their hands. Among these tasks the following[105]:

1. Develop required courses in bioethics and medical humanities (and history of medicine) to be offered regularly and be given important weight. Integration of bioethics throughout should be considered. Assessment methods used should follow Bloom's taxonomy. Students should also be taught bioethics at the bedside. *Ethics Rounds* can thus be established.
2. Alter the spirit of unhealthy learning approaches amidst students: Medical training has been described as a journey that enhances competitiveness, individualism, and even deception. These standards followed by students in order to succeed should be avoided and stand in exact opposition to the ideals of the physician who should think and act in a spirit of community, collegiality, and team work. This disconnect will have to be dealt with early on and no medical school should tolerate double standards.
3. Arrange the structure of salaries in so that there would be a dedicated body of preclinical and clinical teachers chosen for their teaching excellence and rewarded (bonuses and awards) for preserving that excellence. Some faculty members should not be permitted to teach if they reveal a lack of aptitude, talent or good character traits. These faculty members should be left to continue their clinical chores unless their obligations to patient care and ethical skills are in question.

[105] All this will probably require at the beginning some form of a "needs survey" in order to see what students and faculty see as important for their education (in order to bridge the gap between theory and practice).

4. Remove bad role models from the core faculty in order to be able to start building a healthy hidden curriculum in terms of professionalism. As Cohen argued, whatever doctors do is often worsened by them being teachers (in Erde, 1997, p. 32). In addition to that, little details like the decorations of the teaching hospital to which the student is exposed need to be carefully considered. This has a psychological effect on the moral development of the neophyte physician.
5. Much less tolerance should be given to poor professional performance. It ought not be assumed or taken for granted that everyone who gets into medical school and meets the academic requirements will eventually graduate. Professional and character requirements are as important as academic requirements.
6. Find faculty 'peer-sellers' for bioethics from the various departments and help create a "hub and spokes model"[106] where a main bioethics resource person (the core hub) will be responsible for sharing ethics knowledge and offering advice, as well as providing support and guidance to designated faculty/staff at the teaching hospital. In turn, there will be "spoke leaders" who will be in charge of supporting and assisting others in their departments and programmes. Each spoke will consist basically of a programme with a designated leader in charge. The leader will, in coordination with the main hub person, who should be a person in a position of power who possesses phronesis (eg. Associate Dean for Medical Education or the Director of the Bioethics Program), designates members who will be working with him (or her) as mini-spokes and thus constituting his (or her) team. Further, spoke leaders will have their own sub-spokes who will work on developing the programme even further. This will

[106] An analogous "hub and spokes strategy" has been piloted at the University of Toronto's Joint Centre of Bioethics (MacRae et al., 2005, pp. 256-261).

eventually function and spread slowly but smoothly following a ripple effect. This will guarantee "integration, sustainability and accountability" (MacRae, et al., 2005, pp. 256-261).

7. Holding a number of "training teachers" sessions at intervals in order to increase the cadre of faculty members who are able to feel comfortable teaching ethics and mentoring students.

8. Work on promotion criteria. Faculty members, and mostly as a follow-up to the Flexner Report, are rarely promoted for their teaching skills, being humane, good role models, or for caring for the sick but on the number of NIH and foundation grants they get and publications they bring out (regardless of how). The proposed change has to be in the direction of acknowledging the teaching and service faculty which has a bearing on the making and sustaining of the virtuous physician in terms of incentive.

9. Policies and procedures that can protect as well as support trainees who report and seek to change unethical practices should be developed.

10. Penalties should be upheld when moral breaches take place. Physicians affiliated with medical institutions and who commit serious breaches should not be allowed to continue their affiliations with these institutions. Sanctions should be made on a larger scale by the body of medical associations in each country and by the World Medical Association. In the absence of such sanctions, it becomes the duty of medical schools to call for them.

As mentioned previously, medical students enter medical school with some idealism. They can become dehumanized along the way if they are exposed to wrong role models and if

they are abused by the faculty around them (as it has been the case in many medical schools[107]).

As good examples of faculty members and actual good ward experiences on the one hand accumulate, collide and blend together with bad examples of faculty members and bad ward experiences on the other, professionalism and its virtues are either formed or depleted.

4.3. Obstacles Awaiting the Post-Flexnerian Revolution:

The majority of large organizations like medical schools are loaded with institutional impediments that stand in the way of change. As pointed by Elliott and his colleagues, "[t]heir very structures can be impediments to the horizontal communication and cooperation necessary to effect broad-based innovation" (Elliott et al., 1993, p 37). Other such challenges include the nature of the curriculum change itself, the degree to which the faculty entrusted to teach the new courses or material are knowledgeable of the subjects they are asked to transmit to the students, the predisposition of the students themselves to be receptive to matters of ethics and whether they are ready for character change (peer pressure being a major obstacle in modern day society where anything related to virtues and ethics is seen as a weakness), disparity between personal beliefs of faculty members and the values being taught in the new bioethics courses. To this can be added the already prevailing time restrictions particularly in an already overloaded curriculum. The problem of territoriality is another serious problem that is often faced when a change is about to take place: when well established faculty members are not part of the team conducting the

[107] See Feudtner and Christakis (1994) "Do Clinical Clerks Suffer Moral Erosion" referred to in chapters 2 and 3.

change, they refuse to cooperate[108]. There are also attitudinal obstacles that are hard to deal with. It will be difficult to weed out physicians who, though not virtuous, are well established. As long as these physicians are on the wards, they will continue to be, one way or another, a role model (albeit a negative one) or an indirect teacher to at least one of the neophyte physicians. They will be akin to a virus that might spread and become contagious and that should be removed from the institution. The problem becomes more pervasive when this physician is a highly qualified one in terms of skill. The administration should be clear on what its priorities are. Another serious problem faced is that of funding: financial support will have to be available to support the changes in place (from releasing faculties and hiring new ones, to establishing awards and decorating walls). Finally, and perhaps the most important challenge that arises is the following: it will indeed be quite difficult to identify from within the system the virtuous Pellegrinian physician (the philosopher-king). One might identify one if one is already out there[109] but, one has to be realistic and admit that one might have to wait till such a person graduates from within the institution which will take some time and gigantic efforts. Or, it can happen that this person might parachute from nowhere: if the school appoints a Dean of Medicine from outside who happens to possess all the requisite qualities to make the changes[110]. The main point of this argument is that in order to start a revolution (in this case within the medical school) the right rebel or revolutionary will have to be found. He(or she) will have to be a phrominos, courageous and determined to make the necessary changes regardless of the obstacles that might face him (or her).

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[108] This can be overcome by involving good people slowly as the spokes of the main programs.

[109] *Who is to identify this person and according to what criteria*? are pertinent questions.

[110] It can also be that this person possesses most of the qualities requisite for making the changes and that he grows in character and phronesis as the change takes place through a process of continuous learning and self-maturing.

4.4. A Return toVE**:**

The immense challenge if one were to actually allow the materialization of all the above, which centers on fostering the desired attributes of a medical professional, lies in minimizing the presence of bad role models among faculty and staff as well as coming up with a mechanism that will miniminize, if not eliminate, the lack of professionalism that is prevalent in most post-Flexnerian medical schools[111]. The question "*How to go about doing this?"* is a fundamental one. The most important step in this direction is the alignment of the formal curriculum with the informal (and hidden) curriculum. In other words, all forms of curricula should speak the same language and the prevailing disconnect will have to be minimized if not eliminated altogether. For this to happen, a revival of virtue theory in the healthcare profession will have to take place. In other words, the professionals involved in the making of what I call the 'post-flexnerian revolution' will have to be virtuous professionals (what I called Pellegrinian physicians or Pellegrinian philosopher-kings). One of the reasons this is needed (as well as possible) is the fact that although the theory known as principlism - presented by Beauchamp and Childress (1994) - has gained wide acceptance for decades, it is now being considered as not enough for a medical professional to fulfill her professional role. Thus, some argue that the principles are too abstract and removed from the tangibility of clinical experience to the extent that decision making becomes difficult and too rationalistic thus holding back empathy and moral imagination (Clouser and Gert, 1990, pp. 219-36; Carse, 1991, pp. 5-8; Clouser, 1995, pp. 219-236). The call for a VE in professional roles (to use the words of Oakley and Cocking), is in line with the conception of the ends of medicine presented in chapter one

[111] Here again the importance of the organizational structure appears but this too will have to be on the list of the "Pellegrinian physician". Inevitably, she will have something to start with. Possessing the wisdom that she has, she will know from where to start and how to handle things prudently and diligently.

which is basically the one proposed by Pellegrino and Thomasma: it is a theory based on the fact of illness (persons become patients when they realize they are ill and dependent), the act of profession (an act of tacit promise making to help) and the act of healing (which is basically the telos of medicine). In his *Nichomachean Ethics* (1996), Aristotle talked about the development of virtuous persons and he spoke about what it means to be a good member of a society. In the teaching hospital run by the Pellegrinian philosopher-king, virtuous physicians will be developed who will thrive in a good atmosphere and will continue to be trained in the virtues. There cannot be a reform of the student without the reform of the faculty and there can be no reform of the faculty without a reform of the system. It is this reform that will save the medical profession from its downfall and the deprofessioanalization it has been a prey to for a number of years.

This chapter dealt with the actions/steps that medical schools can take in order to accomplish the task of graduating physicians who will do the right thing even when no one is looking. I argued that this is done mostly by working with physicians who will serve as role models and mentors in the appropriate institutional culture. For this to happen, a resurgence of virtue theory in medical education is needed. I hope this chapter has made clear that there is a need for a post-flexnerian revolution that will ensure medical schools will end up graduating the virtuous physician and that this revolution will ensure that all kinds of curricula speak the same language. It is only then that mentors will model by word and deed the ethical nature of the medical profession and the schism that separates theory and practice will disappear.

4.5. Conclusion and suggestions for further research:

I have argued that medicine is a moral endeavour and the ends of medicine are internal to the profession. As a result, medical schools need to educate students in ethics and the virtues. I have also argued that Aristotle's VE is a suitable framework for the moral development of medical students during their years of training. Henceforth, VE ought to play an important role in the formation of the neophyte physician who will do the right thing even when no one is looking. Students become physicians, wear the coat and feel empowered. In Plato's *Republic* (1947, pp. 43-44), Gyges misuses the power of the ring he found. He uses it to do things that are morally objectionable. In our new medical school that follows the model of the post-flexnerian revolution, one might argue that there is a need to guard our Pellegrinian philosopher-king (queen) from abusing the powers that he (or she) has for purposes that are different from the one's for which they were initially given to him (or her). But is there really a problem there? Since we have posited from the beginning that he (or she) is a person possessing the requisite virtues and is constantly being trained in them (like Aristotle's athlete), that he (or she) also has the crowning virtue of phronesis, then one can safely argue that the character of this physician-philosopher-king (or queen) will guard him (or her) from abusing or misusing whatever power he (or she) may have and that he (or she) will continue to do the right thing even when no one is looking. That being said, one can also argue that this physician-philosopher-king (or queen) will be the role model of all role models. Henceforth, to him (or her) can be entrusted the mission of educating future physicians to be the sort of physicians who will do the right thing even when no one is looking. He (or she) will lead the medical school with a faculty that will help students internalize the virtues of medical professionalism in such a way that they will not graduate from the school having been a prey to the moral schizophrenia referred to in chapter one, and without developing cynicism and losing sight

of what the profession of medicine actually is. For this to happen, students will have to be educated in virtues and not simply follow rules and act out of fear of punishments or penalties. They will have to develop an honoring of the profession of medicine and its ends, not a simple reverence of rules and sanctions. In other words, the Pellegrinian philosopher-king (or queen) can be entrusted to run an institution that will produce the virtuous medical professional. The virtuous student professional will possess the virtues internal to the practice of medicine. He will, in turn and with time, practice and imitation, develop his phronesis, "medicine's indispensible virtue" (Pellegrino and Thomasma, 1993, p. 84) and will do the right thing even when no one is looking.

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